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ONE THOUSAND UNSUCCESSFUL CAREERS<sup>1</sup>

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Dr. Salmon once referred to psychiatry as the "stepchild of medicine, it having been born in the poorhouse." Therefore it seems appropriate for a psychiatrist to return to the poorhouse and study the sources from which his specialty reputedly came.

According to Sorokin(1), every society which has ever been studied has been stratified. This has worked out in different ways, from the elaborate caste system of India, and to a lesser extent in Europe, to the allegedly caste-free society of America. Yet, whatever one may call it, in the flow of humanity through life's course there are unequal degrees of success and failure. From time immemorial man has, either from custom or from some evoked response, tended to applaud success and to depreciate failure. Veblen(2) classifies callings as "honorific" and "ignominious." Success has always been honorific and society, in the main, is little interested in the means by which it is attained; while failure is ignominious, and again society has not shown great interest in the alibis explaining this.

As a result of the above, there are certain categories of persons who get a low rating on the scale, and there is surprisingly little information as to who these persons are and the factors causing, or at least associated with, their failure. That there have always been such is attested in many ways. In *Leviticus*(3) we find a list of handicapped persons:

And the Lord spake unto Moses, saying,  
Speak unto Aaron, saying, Whosoever he be of thy seed in their generation that hath any blemish, let him not approach to offer the bread of his God.  
For whatsoever man he be that hath a blemish, he shalt not approach; a blind man, or a lame, or he that hath a flat nose, or anything superfluous, Or a man that is broken footed, or broken handed,

Or crook-backed, or a dwarf, or that hath a blemish in his eye, or be scurvy, or scabbed, or hath his stones broken;

No man that hath a blemish of the seed of Aaron the priest shall come nigh to offer the offerings of the Lord made by fire; he hath a blemish, he shall not come nigh to offer the bread of his God.

The Act of Elizabeth 43 lists them as follows(4):

1. The children of parents unable to keep or care for them.
2. Adults with no means of support and no trade.
3. The lame.
4. The impotent.
5. The old.
6. The blind.
7. Inmates of public prisons.

More recently, in Warner's *American Charities*(5), published in 1894, the causes of poverty are given as:

Indicating Misconduct:

- Drink.
- Shiftlessness and inefficiency.
- Crime and dishonesty.
- Roving disposition.

Indicating Misfortune:

- Imprisonment of breadwinner.
- Orphans and abandoned children.
- Neglect by relatives.
- No male support.
- Lack of employment.
- Insufficient employment.
- Poorly paid employment.
- Ignorance of English.
- Accident.
- Sickness or death in family.
- Physical defect.
- Insanity.
- Old age.
- Large families.
- Nature of abode.

To date, however, we have not found authoritative descriptions of the disabilities of incompetent persons. We do not find much interest in these classes throughout antiquity; neither do anthropologists help us much as to their status in primitive societies. A friend brought a photograph from New Guinea showing a tribesman having what might have been progressive muscular atro-

<sup>1</sup> A preliminary report was made at the 104th annual meeting of The American Psychiatric Association, Washington, D. C., May 17-20, 1948.

This work has been aided in part by funds supplied by the United States Public Health Service, the Rockefeller Foundation, and the Grant Foundation.

phy; at any rate, his arms and legs were withered. His associates had built a little stand in a place giving a wide range of vision and daily brought him out there and cared for him quite tenderly. Handicapped persons, according to Margaret Mead, seem to be well treated in Samoa (6). A few sources of this sort are about all we can get. The assumption has been that the handicapped tended to perish in the struggle among primitives. An occasional picture or anecdote refers to such persons in classical times, but we find little record of organized care or study.

The first efforts to extend relief to unfortunates in an organized way evidently came under the auspices of the Christian church. From almost the beginning there were organized groups who gave relief to beggars and helpless persons. There soon grew up hospitals or hospices where a certain number were sheltered. The giving of alms gradually developed into a Christian duty and from very remote times we find bequests, small and large, for such purposes, avowedly given to assure the salvation of the soul.

The seizure of church property under Henry VIII resulted in the displacement of a large number of such persons and evoked governmental action in England. The first English laws had to do with the licensing of beggars and were punitive in nature. These persons were called idle, disorderly, rogues, "sturdy beggars," etc. The long history of legislation concerning the licensing of beggars would seem to indicate that this was the conventional method of relieving poverty for many years (7). None of these governmental provisions appears to have been an effort to relieve suffering; rather they were attempts to force indigent persons to work and take care of themselves, and the changes in the law were frequently an increase in the severity of the punishment.

However, in 1598 the whole matter was reviewed, new legislation put into effect, and the former acts repealed. Elizabeth 39 gives an interesting definition of "Rogues, Vagabonds, and Sturdy Beggars":

And be it also further enacted by the authority aforesaid, that all persons calling themselves scholars going about begging, all seafaring men pre-

tending losses of their ships or goods on the sea going about the country begging, all idle persons going about in any country either begging or using any subtle craft or unlawful games and plays, or feigning themselves to have knowledge in physiognomy, palmistry, or other like crafty science, or pretending that they can tell destinies, fortunes, or such other like fantastical imaginations; all persons that be or utter themselves to be proctors, procurers, patent gatherers, or collectors for gaols, prisons, or hospitals; all fencers, bearwards, common players of interludes and minstrels wandering abroad (other than players of interludes belonging to any baron of this realm, or any other honourable personage of greater degree, to be authorized to play, under the hand and seal of arms of such baron or personage); all jugglers, tinkers, peddlars, and petty chapmen wandering abroad; all wandering persons and common labourers being persons able in body using loitering and refusing to work for such reasonable wages as is taxed or commonly given in such parts where such persons do or shall happen to dwell or abide, not having living otherwise to maintain themselves; all persons delivered out of gaols that beg for their fees, or otherwise do travel begging; all such persons as shall wander abroad begging, pretending losses by fire or otherwise; and all such persons not being felons wandering and pretending themselves to be Egyptians, or wandering in the habit, form, or attire of counterfeit Egyptians; shall be taken, adjudged, and deemed rogues, vagabonds, and sturdy beggars, and shall sustain such pain and punishment as by this act is in that behalf appointed.

By 1601, when Elizabeth 43 was put on the books, it would seem there was some recognition that some of these people were impotent and could not work. Elizabeth 35 provided for institutional care:

That all and every person and persons seised of an estate in fee simple, their heirs, executors, or assigns at his or their wills and pleasures, shall have full power, strength, licence, and lawful authority, at any time during the space of twenty years next ensuing, . . . to erect, found, and establish one or more hospitals, maisons de dieu, abiding places or houses of correction, at his or their will and pleasure, as well for the finding, sustentation, and relief of the maimed, poor, needy, or impotent people, as to set the poor to work.

Finally, the Gilbert Law of 1787 definitely recognized the impotence of certain of these persons and a division was made between the worthy poor and the vicious poor. Up to this time the only public institutional provision for such persons had been the prison and there now gradually developed a new institution, at first called a workhouse and later developed into a workhouse and alms-

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house, often under the same roof. Here were gathered a motley group of persons representing every form of human incapacity.

Upon the coming of English persons to Massachusetts, the English law, naturally, came along too. Hardly had the immigrants landed before there were grants in aid of indigent persons. "Dyets for Stephen Fisher" and more "dyets for Stephen Fisher" appear repeatedly in the first pages of the town records of Billerica. The only institutions were the jails and houses of correction; bridewells, these latter were called. Here were confined not only the criminal class as known today but hosts of other persons called "poor debtors." Tremendous numbers of persons were held in these institutions.

Some time after the Revolution, and presumably after the Gilbert Law, workhouses and almshouses came into vogue. We know little about these great institutions. There was a tendency to "sweep the dirt under the sofa" and local town histories give us little information. For instance, the most magnificent one, at Salem, designed and built by Bulfinch, is scarcely mentioned in any of the well-recorded histories of Salem, although the institution still stands there in its somewhat bedraggled grandeur.

From the beginning there was an effort to make these places pay, if not a profit, at least enough to carry themselves. There is a vast amount of literature, largely consisting of sermons, having to do with the struggles to make them pay. The dedication of the chapel of the new almshouse in Portsmouth, New Hampshire, in 1834, called forth a discourse by Charles Burroughs(8), which gives an excellent history of the whole matter. Stress is laid upon the attempt to make such institutions self-supporting. The town reports also emphasize this(9). By 1850 almost every town had a workhouse and almshouse, usually filled to capacity.

The first real scrutiny of inmates of these almshouses began in 1829 in Massachusetts, when a census of the insane in the workhouses and jails was made, and this continued annually. A copy of the 1843 census has survived and we find that about 30% of the inmates of these public institutions were insane(10).

The history of the arousing of the public

to the need of better care of the insane between 1820 and 1850 is well known and need not be repeated here(11). Enough to say that the insane were the first group singled out for special care. Then came the feeble-minded. Even at the present time there is still a large component of mental disease in almshouses.

These institutions began with the most benevolent purposes, but soon became dens of iniquity, filth, and disease. The fear of the poorhouse is said to be the underlying emotional factor in the New England mind. There grew up what was called the "poorhouse test"; that is, if a person was poor enough and helpless enough to be willing to go to the workhouse, his case was considered genuine. Doctors went to these institutions and cared for the dying, but showed little interest in them and took no active leadership in offering a remedy.

Following the great famine in Ireland there was a tremendous exodus to the United States. A large number of refugees came to Massachusetts. These persons were impoverished, spoke with an alien accent, and were Roman Catholics. They were welcomed only insofar as the brawn of their healthy bodies made them good workers. The old settlement law, by which each town was responsible for its own indigent, broke down under this load of unsettled poor. As a remedy, the state decided in 1854 to build 3 almshouses. These institutions were erected at Monson, Bridgewater, and Tewksbury. It will be noted that they were established for the unsettled poor.

Thus began that great stream of submerged humanity going through Tewksbury. The admission numbering has been consecutive since, the present number being around 275,000 (Fig. 1). At first the keeper was a layman and the medical component was as near zero as it could be, with a neighboring doctor on the staff. Gradually medicine grew and lay management dwindled. The history of the past 94 years has seen the constant withdrawal from the unsettled poor classification into the medical classification. In 1869, despite the institution of public care for the insane, there was still a large component of such cases, and buildings were erected for these. This is said to have been

the first provision for the care of the chronic insane in America. By 1883 the superintendent was a physician and since then the medical features have grown, until in 1900 the name was changed from State Almshouse to State Hospital; in 1909, from State Hospital to State Infirmary; and finally, in 1939, to Tewksbury State Hospital and Infirmary. Gradually caretakers were replaced by nurses and the supervision became medical. Formerly many mothers with their children were sent there and the death rate from diarrhoea was tremendous. Then a special hospital for children was developed. Later, special buildings for the tubercular were put up (12).

And so this great institution has grown to date. There are at present 2,108 there, and during the past year 5,200 persons went

individuals into psychiatric classifications. The medical classification is obvious and yet gives little insight as to the kind of persons we are dealing with. The method of study has been as follows: New admissions (random as far as could be determined) have been interviewed by the director, using a blank form with space for the following data:

Name, serial number, Tewksbury number, age, birthplace, father's occupation and birthplace, schooling (highest grade, reason for leaving), occupation (longest period and best wage), health (medical history), domestic life, alcohol and arrests, savings or insurance, relief, present difficulty, medical handicaps, social handicaps, attitude toward career, evidence of deterioration (senile changes).

Information so obtained has then been compared with the social service record in the State House and any additions or corrections made. Then each case has been put through the Probation Department index of arrests in Massachusetts and this material has been added. Finally, the last medical diagnosis, or the most important medical diagnosis, has been added. These records have been tabulated and the statistics compiled.

#### ANALYSIS OF THE DATA

A scrutiny has been made of the characteristics of the population of Tewksbury during the past 94 years. Fig. 2 shows the gradual change in the age component. In the beginning it was comprised largely of children and now consists mainly of older persons. This is purely an artifact. It seems that there are, to some extent, more older persons, but to evaluate properly the significance of this, the fact that children are now cared for in other ways must be taken into consideration. Formerly, if a man died leaving a widow with several children, the whole family was sent to Tewksbury. This, in the main, accounted for the numbers. The effect of immigration, as well as the status of the immigrant, is well illustrated by the dropping off in admissions since immigration numbers have declined (Figs. 1 and 3).

*Nativity.*—A study of nativity shows an excess of foreign-born and a deficiency of Massachusetts-born individuals (Table 1). While this is to some extent accounted for by the selective process by which individuals

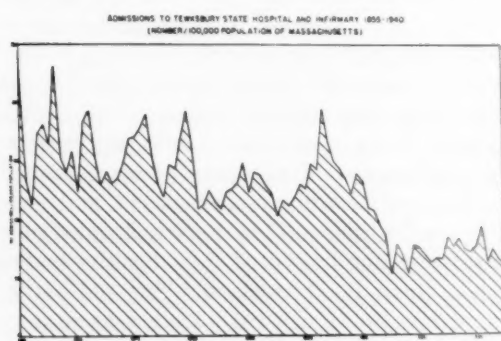


FIG. 1

through. There has been a good deal of excellent medical work, and formerly it was not unusual for persons who had trained at Tewksbury to go on to high places in the medical profession. In 1909 the social service department was established, based, however, upon the State Department of Public Welfare and never directly attached to the institution. Prior to this the only social interest had been a Settlement Officer, who came there to determine settlement.

With this as a background we now come to an analysis of the population. Insofar as we can learn, there has been no study or publication heretofore as to what sort of people go to an institution such as Tewksbury. Although the principal director of this study is a psychiatrist and although in a general way psychiatric techniques have been used, no attempt has been made to crowd these in-

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The unsettled poor of Massachusetts), it also tends to suggest two other hypotheses in explanation. The first of these is that an immigrant is on an exposed frontier; that is, he has come to this country usually without funds, with a language defect, and is only

other trouble, he has no resources in family or friends to help him along.

*Age Distribution.*—Special provisions have been made for the children of the unsettled poor, so that the policy in Massachusetts is not to hospitalize them. The age distribution of the group studied is shown in Table 2. Here it will be seen that there is a deficiency in younger persons up towards mid-life.

TABLE 1

COMPARISON OF PLACE OF NATIVITY: ADMISSIONS TO TEWKSBURY STATE HOSPITAL AND INFIRMARY AND POPULATION OF MASSACHUSETTS IN 1940

| Place of nativity         | TSH and I (%) | Mass. (%) |
|---------------------------|---------------|-----------|
| Massachusetts .....       | 37.4          | 68.4      |
| Other United States ..... | 18.1          | 11.3      |
| British Provinces .....   | 13.9          | 5.4       |
| Ireland .....             | 14.3          | 2.4       |
| Great Britain .....       | 1.8           | 2.2       |
| Poland .....              | 3.0           | 1.2       |
| Russia .....              | 2.1           | 1.5       |
| Italy .....               | 2.2           | 2.6       |
| Lithuania .....           | 1.5           | 0.5       |
| Finland .....             | 1.2           | 0.2       |
| Miscellaneous .....       | 4.5           | 4.3       |

TABLE 2

AGE DISTRIBUTION OF TEWKSBURY STATE HOSPITAL AND INFIRMARY ADMISSIONS COMPARED WITH POPULATION OF MASSACHUSETTS IN 1940

| Ages              | TSH and I (%) | Mass. (%) |
|-------------------|---------------|-----------|
| 15-19 .....       | 0.6           | 8.9       |
| 20-24 .....       | 0.3           | 8.6       |
| 25-29 .....       | 0.5           | 8.0       |
| 30-34 .....       | 1.8           | 7.5       |
| 35-39 .....       | 2.9           | 7.2       |
| 40-44 .....       | 5.7           | 7.1       |
| 45-49 .....       | 8.1           | 6.9       |
| 50-54 .....       | 9.7           | 6.1       |
| 55-59 .....       | 12.3          | 5.0       |
| 60-64 .....       | 18.0          | 4.3       |
| 65-69 .....       | 14.6          | 3.5       |
| 70 and over ..... | 24.4          | 5.0       |

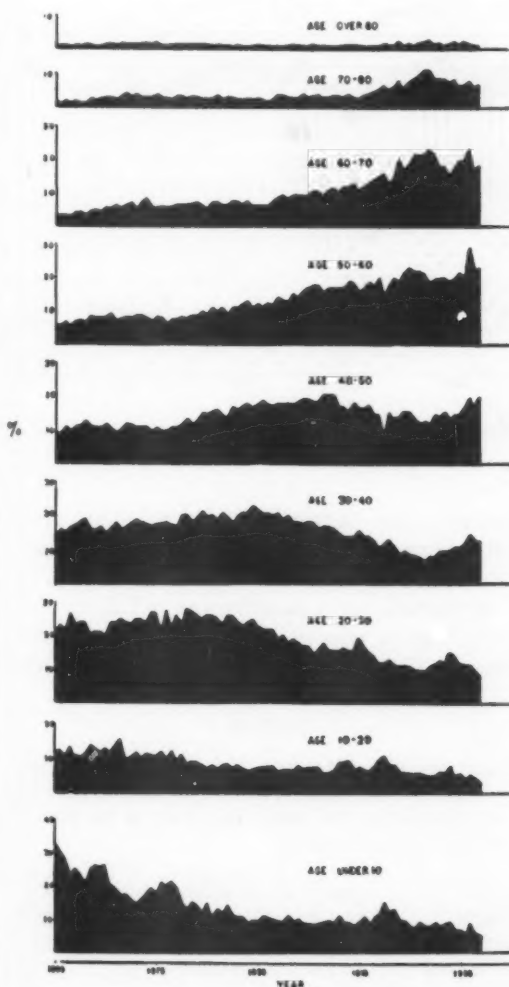


FIG. 2

sought as an unskilled laborer. He has a deficit both in formal education and vocational skill. For that reason he is subjected to a great deal more social pressure than is the native-born. When there is unemployment, he is the first to lose his job, and in the last few years in Massachusetts the immigrant has made up a large percentage of casual labor. Secondly, if he is ill or has

While it is obvious that the vicissitudes of the later years are tremendous, yet it should be noted that the median age of our 1,000 cases is in the 60-64 years group. In other words, the majority of the Tewksbury population are in what should be their productive years.

*Schooling.*—Table 3 shows the school history, and here again we find a deficit in educational accomplishment as compared with the figures for the state. It is not until we

(% OF ADMISSIONS PER YEAR)

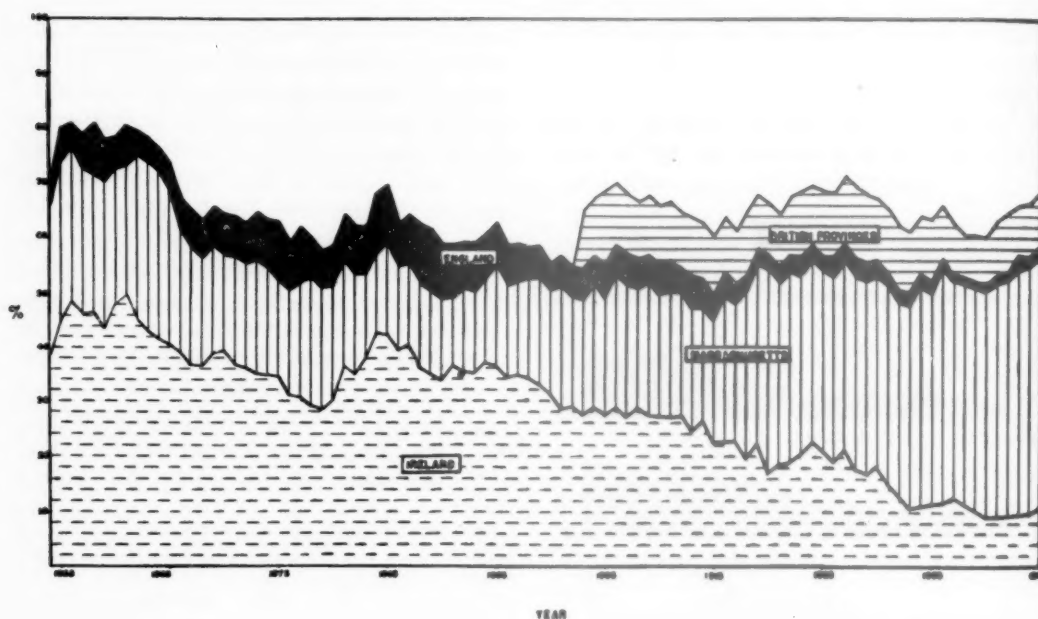


FIG. 3

get down to the sixth grade that there are excessive numbers. Therefore, this population has been subjected to whatever disability comes through inadequate educational achievement. Insofar as we can tell, this is

TABLE 3

COMPARISON OF YEARS OF SCHOOL COMPLETED BY TEWKSBURY STATE HOSPITAL AND INFIRMARY ADMISSIONS AND BY RESIDENTS OF MASSACHUSETTS, 25 YEARS OLD AND OVER, IN 1940

| Years of school completed | TSH and I (%) | Mass. (%) |
|---------------------------|---------------|-----------|
| 13+ .....                 | 2.8           | 10.4      |
| 12 .....                  | 6.0           | 19.9      |
| 9-11 .....                | 15.7          | 18.5      |
| 7-8 .....                 | 24.3          | 30.6      |
| 5-6 .....                 | 18.2          | 8.4       |
| 1-4 .....                 | 19.6          | 6.0       |
| 0 .....                   | 11.8          | 4.1       |
| Unknown .....             | 1.6           | 1.9       |

not due to low I.Q. but to other factors which interfere with progress in school.

**Marital Status.**—It will be seen by Table 4 that the tendency is not to marry. So many of these individuals are foreign-born, casual laborers, rovers, and chronic alcoholics that they tend to be screened out in the marrying process. The excess of widowers is note-

worthy, but particularly remarkable is the large number who have married but have not been successful in the venture.

**Occupational Classification** (Table 5).—Once again, this shows a deficit in achievement. There is a slight excess of skilled

TABLE 4

COMPARISON OF MARITAL STATUS OF ADMISSIONS TO THE TEWKSBURY STATE HOSPITAL AND INFIRMARY WITH MALE POPULATION OF MASSACHUSETTS IN 1940

|                             | TSH and I (%) | Mass. (%) |
|-----------------------------|---------------|-----------|
| Single .....                | 49.0          | 36.8      |
| Married .....               | 8.0           | 57.5      |
| Widowed .....               | 19.0          | 4.8       |
| Separated and divorced * .. | 23.2          | 0.9       |
| Unknown .....               | 0.8           | 0.0       |

\* The Massachusetts figure does not include "Separated."

laborers over this class in the general population of Massachusetts. On the other hand, having interviewed a large number of these persons, I am inclined to take their degree of skill with a grain of salt. But despite this, the overwhelming percentage of unskilled and casual laborers is striking. Whether this is due to lack of opportunity or lack of aptitude may be debatable, although there is

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some evidence that those who are capable of acquiring skill tend to do so. To become skilled requires, in the first place, aptitude and, in the second place, tenacity of purpose, which seems to be lacking in our group. The large number of restaurant and hotel workers shows the tendency of down-and-outers to find a place in this sort of work.

*Major Diagnoses* (Table 6).—Although practically all the cases have some medical

TABLE 5

COMPARISON OF HIGHEST OCCUPATION HELD BY TEWKSBURY STATE HOSPITAL AND INFIRMARY ADMISSIONS WITH OCCUPATIONAL DISTRIBUTION IN MASSACHUSETTS IN 1940

| Classification                 | TSH and I (%) | Mass. (%) |
|--------------------------------|---------------|-----------|
| Proprietor and professional... | 2.4           | 19.4      |
| White collar .....             | 5.9           | 16.7      |
| Skilled .....                  | 21.7          | 19.3      |
| Unskilled .....                | 51.5          | 43.7      |
| Casual .....                   | 16.8          |           |
| None .....                     | 0.9           | ...       |
| Unknown .....                  | 0.8           | 0.9       |

TABLE 6

CLASSIFICATION OF MAJOR DIAGNOSES OF TEWKSBURY STATE HOSPITAL AND INFIRMARY ADMISSIONS

| Diagnosis                            | Percent-age |
|--------------------------------------|-------------|
| Alcoholism .....                     | 37.0        |
| Cardiovascular .....                 | 18.6        |
| Neuropsychiatric .....               | 8.6         |
| Senility .....                       | 5.4         |
| Upper respiratory .....              | 5.8         |
| Arthritis .....                      | 3.5         |
| Genito-urinary (inc. V. D.) .....    | 3.1         |
| Skin .....                           | 1.6         |
| Cancer .....                         | 2.0         |
| Metabolic .....                      | 1.3         |
| Orthopedic and sensory defects ..... | 2.4         |
| Gastro-intestinal .....              | 1.6         |
| No chronic disease .....             | 9.1         |

diagnosis, in the main the medical disabilities tend to be trivial. There is a small number of persons who have serious incapacitating disease as their sole problem, but this number is insignificant. The majority of them are serious social problems, with disease a relatively minor factor. It is interesting to note that, despite the tendency to use another diagnosis when possible, in 37% the only diagnosis possible is alcoholism. There are comparatively few insane and comparatively few feeble-minded, most of the insane being

cases of senile dementia. There is a small number who may be unrecognized hebephrenic dementia præcox cases. As one goes through a ward, the apathy and indifference are strongly suggestive of a ward for mental disease. The concept of personality disorder, as conventionally used, is seldom warranted. If we use the classical division of social problems—sickness, poverty, and crime—all we can say is that some of these individuals are predominantly sick and incidentally poor or bad; others are predominantly poor and incidentally sick or bad; while others are predominantly bad and incidentally sick or poor.

Superficially, the most striking thing about the group is the devastating effect of alcohol. Sixty percent have had arrests for drunkenness (Table 7), the maximum for an indi-

TABLE 7

PERCENTAGE OF ADMISSIONS TO TEWKSBURY STATE HOSPITAL AND INFIRMARY ARRESTED FOR VARIOUS OFFENSES

|                   | Percent-age |
|-------------------|-------------|
| Drunkenness ..... | 60.5        |
| Acquisitive ..... | 13.8        |
| Pugnacious .....  | 9.8         |
| Procreative ..... | 3.2         |
| Other .....       | 32.3        |

vidual being over 200. However, arrests for drunkenness are not as specific as had been supposed, as we find in these records many other evidences of social demoralization. Many long-time chronic alcoholics have never been arrested.

Back of all this, the trajectories of the lives of these individuals show a striking similarity. There is no evidence of racial or familial inferiority. These persons have not done well in school. They have gotten along poorly in industry or their jobs, there being very few who have worked steadily for long periods of time or have acquired great skill. If they have married, the marriage tends to end in disaster, and many express an utter indifference as to the whereabouts of wife or children. Most of them were problem drinkers at the age of 30. They start coming to Tewksbury along in mid-life, primarily because they are down and out, and the im-

mediate cause of this is often alcohol, or, less frequently, some physical disease.

How shall we characterize this group from the psychiatric standpoint? The patterns and formulæ of their lives show great similarity. It is not possible to squeeze them into the categories of mental disease, however much elasticity we may be willing to use. Yet they have never functioned successfully in a competitive society. Their relatives and friends would have nothing to do with them; they have worn them out or shamed them to the point where they wished no further contact. How much of it is biological and how much sociological we cannot say.

#### SUMMARY

Since time immemorial society has dealt with the problem of poverty on a moral basis. Success has been honorific and failure ignominious, and so handicapped persons failing to make the social grade have been judged by the method of moral evaluation. The terms "lazy," "improvident," "vicious" have been used as terms of reproach. Each advance in civilization has led to a changed technique in dealing with human failures; but in general, all have tended to attribute the squalid condition of the poor to individual qualities.

Latterly there has been a change in attitude. There has been more solicitude for the common man and his welfare and less willingness to allow avarice and greed to go unchecked. The tendency has been away from scrutiny of the individual and toward scrutiny of social organization. Sociologists in particular have attributed the plight of handicapped classes to social disorganization, and vast plans have been made for their relief, with very little information concerning the personality of the individuals involved. Medicine has a place in the social sciences and psychiatry is, in a way, the social wing of the medical profession. For this reason it seemed important to make a critical survey of a substantial number of welfare recipients with a view to determining what their personal qualities and their personal problems were.

Our study involved 1,000 admissions to a large state institution, formerly called a

workhouse, latterly called a hospital. It has been a reconnaissance study and therefore exact measurements did not seem applicable. At any rate, the preliminary study was made by examination of the natural history of the organism; that is, what has been the record in functional terms of the trajectories of these persons' lives?

The results are simple. The individuals show an excess of immigrants; a deficit in formal education, in occupational skill, and in marital success. We do not find a preponderance of catastrophic illness, but we do find alcohol to have been an important factor in the failure of these individuals to make a successful adaptation. Our experience indicates the need of further psychiatric inquiry into this field, as the techniques of psychiatry seem to be peculiarly applicable. The data suggest the possibility of poverty often being secondarily economic and primarily either due to chronic illness or behavior disorder.

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## DISCUSSION

DR. DAVID C. WILSON (Charlottesville, Va.).—Dr. Southard described Dr. Stearns as his cavalry scout, the one who rode ahead to locate the enemy forces, flushed them so to speak, then after so locating and describing their general configuration rode on to the next. This study is classified by its author as superficial, and superficial it is when the deeper causes of individual degradation are sought. But when the orientation of poverty, of nonsuccess in the unfolding panorama of life, is considered, the impact of this piece of work is far from skin deep for, by its overt as well as implied uncoverings, it penetrates deeply into the social structure. "The poor are always with us" is an axiom as old as man. Yet Dr. Stearns points out that few studies have been made which try to answer why the poor are always with us. We pour millions into the care of the dependent; cities impoverish themselves to support the unsuccessful; yet no one seeks the fundamental laws or rules which lead to unsucccess in a culture whose watchword is progress. Dr. Stearns shows that physical handicaps, that disease, that the ageing process have no relation to this social condition. The state of unsucccess is an apparent inability to get along which if not inborn develops early in life, then characterizes the behavior of these individuals regardless of their physical or mental condition. They represent the sediment that settles to the bottom regardless how often the cup is stirred.

The lack of affect of many of these persons suggests the apathy sometimes seen in prisoners of war. Isn't it possible that these Tewksbury inmates, when early in life they faced the realities of human struggle, found themselves unable to survive except in this anti-successful fashion so that unsucccess became, so to speak, a pattern of defense, and to never try became the only way to get along. Certainly if this is so, and Dr. Stearns' study would indicate that it is, then many of our attitudes toward the chronic poor only perpetuate the pattern of unsucccess. It is vital that his study be carried on until it is known whether the poor represent many individuals with as many causes for

their plight, or whether they are victims of a way of life which insidiously engulfs human beings, a social disease, a fixed pattern of human behavior.

Dr. Stearns should be given aid to collect more definite data, so that it can be known that these individuals do not represent examples of the mental diseases such as simple schizophrenia or certain forms of psychopathic personality. Rorschach studies, perhaps group Rorschach, would be practicable.

It is vital, it seems to me, to know why they are in the poor house instead of the penitentiary. Perhaps their siblings are there. If we are to pay such persons \$25 a week or some more fantastic figure to insure their nonsuccess, to perpetuate their poverty, it is high time we found out if there is not some way to prevent this disease of our culture. Our cavalry scout has indeed located an enemy in our midst of considerable proportions.

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## A STUDY OF ONE THOUSAND PSYCHOTIC VETERANS TREATED WITH INSULIN AND ELECTRIC SHOCK<sup>1</sup>

SAMUEL PASTER, M.D., AND SAUL C. HOLTZMAN, M.D.

*Memphis, Tenn.*

### INTRODUCTION

During the war years under the supervision of the Army, and following the war under the jurisdiction of the Veterans Administration, a large number of psychotic veterans were admitted in our hospital both from overseas and the zone of the interior. Approximately one-third of the men whose illness had been precipitated in combat were recovered by the time of their arrival. About one-fifth of the men continued to improve under the socializing influence of the various hospital activities. Those patients who, following a period of observation, manifested no trends toward spontaneous improvement and who were considered incapable of social adjustment, were given shock therapy. A unique opportunity was thus afforded to determine the efficacy of shock therapy in the treatment of psychotic reactions precipitated under conditions peculiar to war.

This study represents an evaluation of 1,000 psychotic veterans treated under our direct supervision during a period of 30 months. Five hundred and seventy men were treated with electric shock; 241 were treated with insulin shock; and 189 were given electric shock followed by insulin shock. Patients who suffered from either phase of manic-depressive psychosis, stuporous catatonics, paranoid schizophrenics who displayed good affectivity, and disturbed psychotic patients in general were given electric shock. Paranoid schizophrenics who appeared dull and apathetic, catatonic patients presenting no difficult problems in management, manic-depressive patients manifesting paranoid trends, and malnourished psychotic patients were given insulin shock. A group of patients who had not responded to electric

shock or who relapsed following the completion of treatment was treated, in addition, with insulin shock. Curare was employed in all the cases treated with electric shock where clinical or X-ray findings revealed either osteoarthritic changes or marked deformities of the spine. The techniques of treatment employed have been discussed elsewhere (1). Both individual and group psychotherapy constituted an integral part of the treatment of these patients. Following the completion of shock therapy, all patients were closely observed for a period of 4 to 6 weeks. Patients who had achieved a social recovery were placed on a rehabilitation ward where a social and industrial program of rehabilitation was carried out. In evaluating the results of treatment, an attempt was made to correlate the extent of recovery with the various factors that may have played a rôle in determining the prognosis and the course of the disease.

### CRITERIA OF RECOVERY

On the completion of the treatment, the patients were examined and classified on the basis of the following criteria of recovery:

*Recovered.*—Those patients who have become symptom-free, gained insight into their episodes of mental illness, are able to discuss their morbid symptoms objectively and with appropriate affect, and who are presumed to have returned to their prepsychotic level of behavior.

*Improved.*—Patients who are no longer actively delusional or hallucinating but who retain some residual symptoms and who have not gained full insight into their illnesses upon completion of treatment. They are, however, considered able to adjust to the community, though not always at the same level as before the onset of their illness.

*Unimproved.*—Those patients who either have not responded to treatment or who had improved during treatment but subsequently relapsed to the pretreatment level.

<sup>1</sup> Read at the 104th annual meeting of The American Psychiatric Association, Washington, D. C., May 17-20, 1948.

From the Neuropsychiatric Service, Veterans Administration Medical Teaching Group, Kennedy Hospital, Memphis, Tenn.

## THE RESULTS OF TREATMENT

The majority of the patients treated were cases of schizophrenia, chiefly of the paranoid and catatonic types. Table 1 reveals a

TABLE 1

## RESULTS OF TREATMENT WITH THE SHOCK THERAPIES

|                           |     |     |
|---------------------------|-----|-----|
| Electroshock:             | %   | No. |
| Recovered .....           | 12  | 70  |
| Improved .....            | 49  | 278 |
| Unimproved .....          | 39  | 222 |
|                           | 100 | 570 |
| Electroshock and Insulin: |     |     |
| Recovered .....           | 24  | 46  |
| Improved .....            | 45  | 86  |
| Unimproved .....          | 31  | 57  |
|                           | 100 | 189 |
| Insulin:                  |     |     |
| Recovered .....           | 24  | 59  |
| Improved .....            | 57  | 137 |
| Unimproved .....          | 19  | 45  |
|                           | 100 | 241 |

high rate of social recoveries achieved with electric shock, insulin shock, and a combination of the 2 forms of therapy. It is worthy of note that 81% of the patients treated with

insulin shock achieved a social recovery. Although immediate results with electric shock were better than those indicated in the table, a significant number of recovered patients relapsed following the termination of treatment. The superiority of insulin treatment over electric shock was especially well demonstrated in the group treated with insulin following unsuccessful treatment with electric shock.

The relative response of patients suffering from paranoid and catatonic schizophrenia to the various forms of shock therapy is revealed in Table 2.

In analyzing the results recorded in Table 2, it is evident that both paranoid and catatonic schizophrenics respond better to insulin than to electric shock. Especially noteworthy is the number of cases recovered under insulin treatment following unsuccessful treatment with electric shock. In common with other investigators, we found that the remissions produced by insulin treatment are sustained much better than those produced by electric shock (2, 3, 4, 5).

## THE PREPSYCHOTIC PERSONALITY

In order to evaluate the relationship between the prepsychotic personality and the

TABLE 2

## RESPONSE OF PARANOID AND CATATONIC SCHIZOPHRENIC PATIENTS TO SHOCK THERAPY

|  | Paranoid |     | Catatonic |     |
|--|----------|-----|-----------|-----|
|  | %        | No. | %         | No. |
| Electroshock Therapy:                                      |          |     |           |     |
| Recovered .....  | 7        | 17  | 8         | 14  |
| Improved .....   | 52       | 119 | 45        | 83  |
| Unimproved .....   | 41       | 97  | 47        | 86  |
|  | 100      | 233 | 100       | 183 |
| Electroshock Therapy followed by<br>Insulin Shock Therapy: |          |     |           |     |
| Recovered .....  | 27       | 23  | 23        | 13  |
| Improved .....   | 42       | 36  | 44        | 25  |
| Unimproved .....   | 31       | 27  | 33        | 19  |
|  | 100      | 86  | 100       | 57  |
| Insulin Shock Therapy:                                     |          |     |           |     |
| Recovered .....  | 26       | 31  | 34        | 11  |
| Improved .....   | 55       | 65  | 32        | 10  |
| Unimproved .....   | 19       | 23  | 34        | 11  |
|  | 100      | 119 | 100       | 32  |

results of the treatment, the following criteria were employed:

*Excellent.*—The patients considered to have had an excellent prepsychotic personality revealed no history of neurotic or psychotic determinants, had a good occupational record, and adjusted well socially.

*Good.*—Those considered to have had a good prepsychotic personality revealed a history of common neurotic determinants. They overreacted to situations of moderate emotional stress, but they had not manifested incapacitating neurotic behavior or malignant mental trends and had adjusted fairly well

veals that a well-integrated personality and a record of social achievement constitute favorable prognostic factors (Table 3). This is especially evident when the remissions obtained among officers are compared with those achieved among the enlisted men. Of the 100 officers treated with the various types of shock therapy, 51% fully recovered, 28% improved, and 21% remained unimproved. Of the enlisted men, 19% recovered, 54% improved, and 27% remained unchanged. Previous attacks of psychosis appeared to have had no adverse effect on the outcome of the illness.

TABLE 3

CORRELATION OF PREPSYCHOTIC PERSONALITY WITH EXTENT OF RECOVERY

|  | Prepsychotic Personality |           |           |
|--|--------------------------|-----------|-----------|
|  | Excellent<br>%           | Good<br>% | Poor<br>% |
| Results of Electroshock Therapy:                   |                          |           |           |
| Recovered .....                                    | 45                       | 11        | 9         |
| Improved .....                                     | 41                       | 69        | 45        |
| Unimproved .....                                   | 14                       | 20        | 46        |
|  | 100                      | 100       | 100       |
| Results of Electroshock and Insulin Shock Therapy: |                          |           |           |
| Recovered .....                                    | 45                       | 26        | 14        |
| Improved .....                                     | 32                       | 52        | 40        |
| Unimproved .....                                   | 23                       | 22        | 46        |
|  | 100                      | 100       | 100       |
| Results of Insulin Shock Therapy:                  |                          |           |           |
| Recovered .....                                    | 53                       | 38        | 18        |
| Improved .....                                     | 40                       | 53        | 54        |
| Unimproved .....                                   | 7                        | 9         | 28        |
|  | 100                      | 100       | 100       |

in their respective communities prior to entering the service.

*Poor.*—The patients considered to have had a poor prepsychotic personality had a past history replete with neurotic determinants and psychopathic traits. They were unable to meet adequately everyday stress and strain. Their occupational records were poor. In civilian life they had often been treated for nervousness. Several of them revealed a history of previous psychotic episodes and institutionalization.

Notwithstanding the unavoidable errors involved in the evaluation of the prepsychotic personalities of the patients, this study re-

#### DURATION OF ILLNESS

The majority of patients included in this survey were so-called "early" cases. Eighty-eight percent (878) of the patients were treated within one year from the time of recognition of their symptoms. The rate of full remissions attained was considerably less among those who had been ill one year or more (9%) as compared with the group whose illness was of 6 months' duration (22%). A steep decline in the rate of full remissions took place among those patients who had been ill more than 12 months, a finding which is in accord with the results reported in the literature(6, 7, 8).

### PSYCHOSES INCURRED IN COMBAT

It is generally recognized that psychotic reactions precipitated under great stress bear a more favorable prognosis. A study of the combat-incurred psychotic reactions reveals a somewhat greater number of full and partial remissions (78%) as compared with the noncombat group (72%). It is important to remember that approximately 33% of the men whose psychotic reactions were precipitated in combat were completely recovered upon their arrival in the States and that 22% continued to improve under the beneficent hospital atmosphere without any specific therapy.

### FAMILY HISTORY

An attempt was made to determine the prognostic significance of the incidence of morbid neuropsychiatric determinants such as psychoses, epilepsy, alcoholism, and criminalism in the blood relatives of the patients. No definite correlation between the family history and extent of recovery could be discerned in this survey.

### COMPLICATIONS

The most important complication in electric shock still remains compression fracture of the spine (approximately 4%). The complications in insulin treatment were negligible. On the whole, the incidence of complications accompanying the shock therapies was low. This is probably due to the fact that we were dealing with a group of patients in the prime of life and that every effort was made to build up the patients physically prior to instituting shock therapy. There were no fatalities.

### SUMMARY

1. One thousand psychotic veterans were given electric shock therapy, insulin shock therapy, or a combination of the two in sequence following a period of observation during which they had revealed no tendency toward spontaneous improvement.

2. The large percentage of social recoveries obtained in this group testifies amply to the efficacy of the shock therapies in the treatment of functional psychotic reactions incurred in wartime.

3. The therapeutic superiority of insulin shock is revealed in the greater number of social recoveries obtained both when it is used alone and following unsuccessful treatment with electric shock. Insulin is definitely more effective than electric shock in the treatment of paranoid and catatonic schizophrenia. The remissions attained from insulin treatment are more lasting.

4. Psychotic reactions precipitated under the stress of combat which had not improved spontaneously responded somewhat better to shock therapy than those patients whose psychotic reactions were precipitated under noncombat, environmental stress.

5. The well-integrated prepsychotic personality proved to be of favorable prognostic significance.

6. The more favorable rate of recoveries reported in this study may be related to the fact that the veterans constituted a selected group of young men in whom the psychotic reactions were precipitated under great emotional stress.

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## FOLLOW-UP STUDIES OF SHOCK-TREATED PATIENTS<sup>1</sup>

JAMES K. MORROW, M.D., AND JAMES P. KING, M.D.

*Radford, Va.*

This study attempts to estimate the long-range effects of the various forms of shock therapy. The material used is a group of private sanatorium patients who were treated with insulin shock, metrazol, electric shock, or a combination of these methods, between 1937 and a date one year before the time of this study. The subshock insulin method and the brief stimulus form of electric shock are excluded. The patients generally were of a middle class economic level. Educational attainments varied all the way up from illiteracy, and were not better than the average of the general population. Most of the cases were relatively acute, but the schizophrenics, in particular, did not differ greatly in severity from those admitted to state hospitals.

The routine of treatment was not ideal. The series includes many who were treated early in our experience with these methods, and many more who had treatment under wartime conditions. The number of treatments averages less than what is now believed the optimum number, as will be noted later. None but the most elementary psychotherapy was used in the psychotic cases.

A total of 686 cases was investigated. Of these, 55 were excluded because treatment was incomplete and entirely inadequate. However, a number of cases were included who stopped treatment prematurely, if the amount given was near the average. Of the remaining 631 cases, it was possible to secure accurate information of about 503. It is this group which forms the basis of this report.

The inquiry was by a questionnaire to patients' families, worded as follows:

1. Is the patient now living at home? In a hospital or institution? If so, where? Elsewhere? Give details.
2. If not now in an institution, is the patient able to do the same work as before the illness? Any work? Give details.
3. If well now, did the patient show the greatest improvement immediately on returning home?

If not, how much later did the greatest improvement occur?

4. If the patient grew worse after leaving (this hospital) how long after?
5. Has the patient been in another hospital or institution for mental or nervous troubles since leaving (this hospital)? If so, give place and dates.
6. Did you notice any bad effects possibly connected in any way with the shock treatment? If so, what? How long did they last?
7. Remarks about the patient's present condition.

Separation of replies obtained from the family doctor or others, where the family had failed to answer, did not reveal any appreciable differences in recovery rates. For that reason, we conclude that patients not traceable would not significantly alter the conclusions here reached. Naturally, we are measuring, by the questionnaire method, mainly the degree of social recovery, though additional information volunteered in many cases has been surprisingly informative.

### MANIC-DEPRESSIVE PSYCHOSES

A total of 63 patients in manic excitements were treated. Of these, 58 apparently achieved an earlier remission with treatment, 3 were refractory, and ultimately recovered spontaneously, and 2 are in institutions, apparently chronic. A number have had more than one attack in the interval covered by the study:

|  |    |
|--|----|
| Treated once only, remission maintained to date. | 46 |
| Treated more than once, remission each time....  | 11 |
| Refractory, finally recovered spontaneously..... | 3  |
| Died years later, mentally well in meantime..... | 1  |
| In institutions, apparently chronic.....         | 2  |

In the 46 cases treated on one occasion only, the average number of electric shocks was 15.9. Only a negligible number had metrazol. The average hospital stay was 58.5 days, and this tends to grow shorter in the cases treated recently. As in the other diagnostic groups mentioned later, the hospital stay represents practically the length of the attack in the acute cases, as treatment was usually started as soon as the diagnosis was

<sup>1</sup> Read at the 104th annual meeting of The American Psychiatric Association, Washington, D. C., May 17-20, 1948.

made. These patients have been out of the hospital an average of 2.8 years, the median number being 2.3 years.

The 3 cases which were refractory to treatment showed no unusual features to explain their failure to improve. They were treated, however, before the more intensive routines used now were begun. One of the cases which has become chronic had been manic and in an institution 3 years before treatment; the other was abandoned by her family and might have recovered under different conditions.

In the depressive phase of the psychosis, of 149 patients treated, a remission was obtained in 134; the remaining 15 did not improve or maintain their improvement:

|   |     |
|---|-----|
| Treated once only, remission maintained to date.                                      | 104 |
| Relapsed, but treated elsewhere, remission....  | 3   |
| Treated more than once, remission each time...  | 23  |
| In institutions now .....   | 9   |
| Treatment ineffective, had lobotomy.....  | 1   |
| Dead: As result of treatment.....   | 1   |
| By suicide (1 in relapse, 1 in much later attack) .....                               | 2   |
| From other causes, later (3 mentally well, 2 in institutions, 1 following lobotomy) . | 6   |

It is noteworthy that, of the 9 cases now in institutions, there is an obvious explanation in at least 7. One had neurotic features, one may have been schizophrenic, one was seriously maladjusted before the illness, etc. In only two is there no apparent explanation of the chronicity.

In the 104 cases treated once only, the average number of electric shocks was 10.6, tending to decrease in the later cases. The average hospital stay was 45 days, also tending to decrease. The average time since treatment was 4.1 years, the median 3.5 years. There were only a few cases treated with metrazol.

In both the manic and depressive phases, no increasing frequency of attacks after shock therapy is shown, though the time interval is still too short for certainty. A few patients who have been treated repeatedly are having attacks at shorter intervals. However, several patients who had had at least two attacks at yearly intervals before shock treatment were given metrazol 8 or 9 years ago and have not yet had another attack. On the whole, patients who are having frequent attacks had such a history before

shock treatment and there appears to be no basis to conclude that shock treatment has tended to shorten the periods of remission.

### INVOLUTION PSYCHOSES

In the involutional group of 45 patients, 32 recovered as a result of treatment, 2 recovered, possibly spontaneously, 6 are at home, improved, but not well, 1 is at home but unimproved, 2 are in institutions, and 1 is dead. In the last case, whether the mental improvement lasted until death is not known. These cases were divided as follows:

|  |    |
|--|----|
| Melancholia .....                          | 28 |
| Recovered, result of treatment.....        | 22 |
| Recovered, possibly spontaneously.....     | 2  |
| At home, improved, not well.....           | 2  |
| In institution, chronic.....               | 1  |
| Died later, had probably not improved..... | 1  |
| Mixed symptoms .....                       | 11 |
| Recovered, result of treatment.....        | 6  |
| At home, improved, not well.....           | 3  |
| In institution, not improving.....         | 1  |
| Died later, improvement not known.....     | 1  |
| Paranoid .....                             | 6  |
| Recovered, result of treatment.....        | 4  |
| At home, improved, not well.....           | 1  |
| At home, unimproved.....                   | 1  |

There were 37 women and 8 men in this group. All the cases typical of melancholia had convulsive therapy, but some of the mixed and paranoid cases had insulin. It is not possible to draw definite conclusions from so small a group. However, there was no noticeable difference in response related to the sex. Most of those still having some symptoms, though able to be at home, either have paranoid ideas or neurotic trends. The depressive symptoms seem to be consistently relieved. It is, of course, probable that cases placed in the paranoid involutional group are actually paranoid schizophrenics.

### SCHIZOPHRENIA

The schizophrenic group is, of course, the most difficult one in which to evaluate treatment results. In this series there were 199 cases so diagnosed, divided as follows:

|   |    |
|---|----|
| Unspecified (no subgrouping clearly justified) .. | 79 |
| Paranoid .....                                    | 45 |
| Catatonic .....                                   | 42 |
| Hebephrenic .....                                 | 16 |
| Simple .....                                      | 12 |
| Acute schizophrenic reactions .....               | 5  |

The large number in the unspecified group resulted from the policy of not assigning a subtype unless the symptoms made the sub-classification quite definite. Some of these undoubtedly were hebephrenic, but had not reached the point where such diagnosis was certain. The 5 acute schizophrenic reactions were clinically schizophrenia, but had had no schizoid background before acute symptoms appeared.

The results, with type of treatment not separated, are as follows:

|   |    | %    |
|---|----|------|
| At home, doing usual work, no further treatment | 92 | 46.2 |
| At home, usual work, had further treatment      | 23 | 11.6 |
| At home, not well, no further treatment         | 28 | 14.1 |
| At home, not well, had further treatment        | 7  | 3.5  |
| In institutions                                 | 42 | 21.1 |
| Dead  | 5  | 2.5  |
| Unimproved by treatment, had lobotomy later     | 2  | 1.0  |

The results were actually somewhat better than these figures indicate. The patients who are at home and able to work, but who have been treated again, have in most cases been well for long intervals, but have been in hospitals for relatively short stays later, usually with some kind of shock treatment being repeated. Of the 5 patients dead, 2 died years later and remained mentally well until death. One committed suicide, 1 died in a state hospital, and 1 died during insulin treatment. If the figures are regrouped with these facts considered, a higher improvement rate is indicated:

|  |     | %    |
|--|-----|------|
| At home, working, with or without repeated treatment, or remained well until death | 117 | 58.8 |
| At home, but not well or able to work  | 35  | 17.8 |
| In institution, had lobotomy, or died while psychotic                              | 46  | 23.1 |
| Died as result of treatment  | 1   | 0.5  |

The schizophrenics in this group who had electric shock received an average of 15.2 treatments. Those receiving insulin mostly had 20 comas, though some had over 30. Both these routines are, of course, shorter than those often used now. The patients in this group who have had no further hospitalization have been at home from a minimum of one year to 10½ years. The average time elapsed since discharge is 3.3 years, though in the median case is 2.4 years.

Results of treatment in the different subgroups have not differed greatly from those reported elsewhere. Of the 117 patients above who were at home and working, after one or more periods of hospitalization, there were:

|       |   |
|-------|---|
| 45 or | 57.0% of 79 unspecified cases             |
| 26 or | 57.8% of 45 paranoid cases                |
| 30 or | 71.4% of 42 catatonic cases               |
| 4 or  | 25.0% of 16 hebephrenic cases             |
| 5 or  | 41.7% of 12 simplex cases                 |
| 5 or  | 100.0% of 5 acute schizophrenic reactions |

Of the catatonic cases above, only 4 have had a second period of hospitalization.

One further consideration of economic importance appears in the information obtained about patients who are now in institutions. These 42 patients are known to have been able to remain at home a total of 495 months, or an average of almost a year each, before commitment became necessary. Many of these had been in state hospitals before treatment.

The duration of symptoms in these patients varied from a day or two to many years. The importance of early treatment is, of course, borne out by comparing results with duration of illness. However, 7 of the patients ultimately committed were treated within a month of showing first symptoms. It is noteworthy, too, that of patients ill over a year (some of them several years) when treated, 12 have been at home and able to work for a minimum of a year, some for several years. Several of these are paranoid cases who are not well, but whose level of adjustment has definitely improved.

Of perhaps even greater prognostic importance is the quality of the prepsychotic personality. In 138 patients, information permitted an estimate of the early personality adjustment as "good," "doubtful," or "poor," based mainly on childhood history, sex and work adjustment, and relative normality of interpersonal relationships. Of those classified as "good," 83% are at home, doing their usual work; 6% are at home, not able to work; 11% are in institutions. At the other extreme, of those classified "poor," only 41% are at home and able to work; 26% are at home, but unable to work; 33% are in institutions.

To determine the indications for each form of treatment is difficult with a series



of this size. About 40% of the cases had combined convulsive therapy and insulin shock and the others are divided. The metrazol group was smallest, since these patients had all been away a long time and were most difficult to trace. Only about 10% of the patients had metrazol alone. The remainder were divided between insulin, about 20%, and electric shock, about 30%. Impressions of the relative efficacy of the different treatments are much as others have described. No definite differences in recovery rates were seen. In the undifferentiated cases who had insulin and convulsive treatment successively, insulin produced a remission after convulsive treatment had failed more often than convulsive treatment succeeded where insulin had failed. This was also true, but less definitely, with paranoid cases. Where these were recent, however, convulsive treatment was usually as effective as insulin, perhaps more so. More acute catatonic cases were relieved of the motor symptoms by convulsive treatment, but insulin seemed more effective in altering the remaining schizophrenic picture after the acute symptoms were relieved. Patients in any group who showed marked loss of affective tone, with sluggishness in bodily functions and particularly with malnutrition, have apparently done somewhat better with insulin.

#### MISCELLANEOUS CONDITIONS

In 47 patients in the series, convulsive therapy was used in various other conditions:

|  |    |
|--|----|
| Psychoneuroses .....                           | 13 |
| Reactive depressions .....                     | 10 |
| Functional depressions of presenile onset..... | 7  |
| Paranoid states .....                          | 5  |
| Undiagnosed psychoses .....                    | 4  |
| Senile depressions .....                       | 3  |
| General paresis .....                          | 2  |
| Presenile (organic) psychoses.....             | 1  |
| Schizoid personality .....                     | 1  |
| Psychosis with organic brain disease.....      | 1  |

Few psychoneurotics were included because shock therapy has not been considered the appropriate treatment except for the preliminary abolition of certain symptoms. Of 3 extremely acute hysterical cases, 2 were relieved and have remained symptomatically well, and a third case later had subshock insulin with relief. In 10 other cases, con-

vulsive therapy was used to overcome severe depression. These patients mostly had neurasthenic symptoms. All these are at home, but in only one case does information indicate normal efficiency or freedom from complaints. Depression seems to be only temporarily relieved in such patients unless other measures are used. Too sudden and complete relief of depression also causes the patient sometimes to refuse other forms of treatment until the previous state recurs.

The reactive depressions are listed separately, because this is an unsatisfactory classification. Some were neurotic, some undoubtedly psychotic. One is dead, and the other 9 are all reported free of depression since treatment. There were also 7 depressions occurring between the climacterium and senescence in which the relief did not seem to differ from that in younger patients in depression. In 5 paranoid states, 2 patients seem to have remained free of delusions and 1 shows better behavior. Of 3 senile depressions, one patient has remained well, one has relapsed after a year, and one has died later. Two paretics in excited states were quieted without ill effect. The other cases listed showed no benefit.

#### MORTALITY AND RISKS

There were 2 deaths. One was a woman in a severe agitated depression who was given electric shock despite the presence of cardiovascular syphilis. She died in apnea after the first convulsion. Autopsy revealed no definite cause of death. One hebephrenic male died in irreversible insulin coma. These have been the only deaths in approximately 1,000 cases including the later ones excluded from this study.

One patient died of pulmonary tuberculosis 16 months after combined treatment and 2 died in cardiac decompensation several months after convulsive therapy. It is possible, though unlikely, that the treatment given may have affected the later progress of these disorders.

With insulin, there was one severe burn of a hand, and one brachial plexus injury which required several months for return to normal function. With convulsive therapy, there were several known vertebral fractures, none of which required any orthopedic

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treatment. There were a few cases wherein pain in the back was complained of for a year, or more, with eventual disappearance. Three patients with vertebral fractures were treated afterward with electric shock and curare without aggravation of symptoms. Only 2 other fractures occurred, one of the scapula and a minor one of the mandibular joint surface.

Few later sequelæ were mentioned in the information. One case may have developed spontaneous convulsions. Memory disturbances were complained of frequently, in a few cases for several months, following convulsive therapy.

With the physically ill, acutely psychotic patient, there always comes a time when we must weigh risk against risk. In most patients with physical disease, the feared danger of treatment has actually proved less grave than the risk of allowing the psychotic behavior to proceed.

#### COMMENT

In the affective disorders, convulsive therapy so greatly shortens the illness that its choice can hardly be questioned. Maintenance of general health and nutrition, prevention of exhaustion, avoidance of long hospital residence, and reduction of suicide are among the advantages. It is quite true, as mentioned in recent publications, that a mild excitement or depression can be managed without shock therapy. But in severe cases, treatment is best started as soon as diagnosis is complete. Delay only lengthens hospitalization and magnifies the risks inherent in the psychosis. No evidence was developed that the manic-depressive cycles occur with greater frequency following convulsive treatment. It seems doubtful that the succession of attacks is much altered.

Only 1 of 199 schizophrenics and 2 of 149 cyclic depressions in this group were suicides, one of these in a later attack, possibly preventable. The risk of suicide is greatest after the first one or two shocks. Several such attempts occurred, none of them successful. Though neither insulin nor convulsive therapy finally answers the problem of schizophrenia, patients who have had either or both have apparently maintained a better level of function for a longer time than pa-

tients not so treated, and remissions which might have occurred spontaneously have been hastened. It is true that considerably higher spontaneous remission rates in schizophrenia have been reported recently than before. One wonders whether "schizophrenia" has not been too often diagnosed, and if some cases so named have not really been affective disorders. Every effort has been made in this series to exclude all doubtful cases. Inasmuch as electric shock can be given more rapidly and simply, it seems rational that most schizophrenics should have its use tried first, reserving insulin for those cases not improving. Routines of both types of treatment should perhaps be somewhat longer than the averages here mentioned.

Shock treatments are adjuncts and nothing more in the treatment of neuroses. They can best be used for the relief of specific symptoms only, with realization by both the patient and the physician that they are no solution of the basic trouble.

The necessity for accurate diagnosis remains. The shock therapies have a great field of usefulness, but one still needs to know what is being treated. In this present period of critical appraisal of the shock therapies, it is to be hoped that criticism of their abuses will not obscure their very real addition to our therapeutic resources.

#### DISCUSSION

MATTHEW T. MOORE, M.D. (Philadelphia, Penna.).—The splendid paper just presented is another cogent page in the evidence piling up to the effect that in properly selected cases, shock therapy has proved to be the greatest single advance psychiatry has made in the treatment of the psychoses.

Some medical philosophers have berated the use and questioned the justification of the destructive procedures of frontal lobotomy and topectomy and the apparently terrifying ruggedness of the various forms of shock therapy in the treatment of psychoses. Until the day when medical science has devised a biochemical scalpel displacing frontal lobotomy and its recent modifications, and a gentler procedure than the shock therapies, we must avail ourselves of the demonstrated advantages of these methods of treatment, as has been attested to by numerous reports in the literature.

Since the development of the several forms of shock therapy, increasing experience leaves no doubt as to the great social and economic gains which have been made. Compared with the preshock era, in terms of sick-bed days, financial outlay, work

hours, emotional stress and strain, our present methods have resulted in savings both to society and industry which are incalculable. With these facts established, to the satisfaction of most clinical workers, we have now entered upon the phase of a critical evaluation of the over-all reported results. This should lead eventually to the setting up of more definite criteria than now exist, regarding the specific application of either insulin or electric shock or both, to certain specific types of psychoses or psychoneuroses, and conversely to interdict the shock modalities for some forms of mental disorders.

The authors are to be commended for again calling to our attention the need for a standardized definition of the terms recovery, improved, unimproved, etc., if we are to evaluate correctly our collective data. The results reported here in the manic-depressive and involutional psychoses mirror substantially those given throughout the literature. The authors stated that in the manic group of 46 cases treated on one occasion only, the average number of electric shocks was 15.9, and in the 104 depressed patients given one course of electric shock, the average number of inductions was 10.6, with a reduction in number of treatments in later cases. In the series of 2,181 cases which I reported in 1946 the average number of electric shock treatments was 9.5. This stirs up the question as to how many electric shocks should be given in the affective psychoses. Many workers have sharply reduced the number from the early arbitrary total of from 12 to 20, and give in the vicinity of 4 to 10 shocks. Others and myself included feel that, as soon as a patient with a manic-depressive or involutional psychosis shows marked improvement to shock therapy, no matter how many treatments have been given, treatment should be terminated or at most one more treatment given, and the patient kept under observation. Should relapse occur one or more further shocks can be given. If on the other hand treatment is arbitrarily continued to round out a set number of shocks, there not infrequently is a reversal of the good effect achieved, and the patient is precipitated into an unnecessary relapse.

At this point, I should like to introduce what may be a controversial issue. That is, are we justified in giving electric convulsive treatment to patients with cerebral arteriosclerosis? Some are

rabidly opposed to shock therapy under such circumstances for fear of possible cerebral damage. In our hands, judicious use of ECT has been entirely safe in such patients, and has been employed as a differential diagnostic tool to distinguish true depressions in the aged from cerebral arteriosclerosis with psychosis, and also to remove depressions occurring in individuals having cerebral arteriosclerosis.

We are in accord with the authors concerning the difficulty in appraising results in the schizophrenic groups. Their results however indicate the worthwhileness of present therapies over the former conservative custodial care. At the present time, we are in the process of critically examining the results of treatment with insulin and electric shock in 700 schizophrenics treated at the Philadelphia Psychiatric Hospital, from 1940 to January 1, 1947, from among total admissions of 3,097 patients to date. Of these 700 cases, 251 were paranoid schizophrenics, 230 catatonic, 136 simple, 70 hebephrenic, and 13 unclassified. It will be seen that the relative percentage of the first two are essentially the same as the authors', but the frequency of simple and hebephrenic types are reversed. At the time of discharge from hospital, 17% had recovered and 77% comprised both recovered and improved categories. The remaining 23% were unimproved. This high percentage of improved cases cannot be properly compared with the authors' groups, since they have not as yet been broken down in terms of follow-up sustained improvement, relapses, subsequent treatment, etc. These data are submitted merely to emphasize the authors' conclusions regarding the value of shock therapy in schizophrenia.

Just a word concerning the psychoneuroses. It has been our experience that with only a few exceptions, shock therapy is not indicated in the treatment of the psychoneuroses, and indeed it might complicate matters by adding further psychic trauma.

The authors have reported two deaths in 1,000 cases, and relatively few complications in this series. In the light of our increasing knowledge concerning the applicability of shock therapy even in cases complicated with somatic disorders, the results reported here have been excellent, and the manner in which treatment has been directed is further testimony that psychiatry is coming of age.

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## SEVEN YEARS OF EXPERIENCE WITH MODIFIED INSULIN TREATMENT IN NEUROSES AND EARLY PSYCHOSES<sup>1</sup>

WILLIAM SARGANT, M.B., M.R.C.P., D.P.M.,<sup>2</sup> LONDON, ENGLAND

Most psychiatric journals in the last year or two have contained reports on the value of modified forms of insulin treatment for a variety of psychiatric conditions, particularly the neuroses. And if one reviews the literature it is obvious that the value of insulin in psychiatric states, apart from schizophrenia, was recognized long before World War II by individual workers. Reports actually date back as far as 1929. It did seem, however, to take the war to popularize such treatments, to enable us to work out satisfactory methods of handling them on a large scale, and to find out more about the correct indications and contra-indications.

Together with Dr. N. Craske, I reported the value of modified forms of insulin treatment in the war neuroses in 1941 (1, 2). Following this report, the treatment was widely used in military and later in civilian cases. Now after a further 6 years it seems worth while to look back on our work and try to summarize some of the conclusions which we have reached.

Over 15,000 civilian and military patients passed through the wards of Sutton Emergency Hospital Neuropsychiatric Unit<sup>3</sup> alone for treatment in the past 8 years, and around 1,000 had modified insulin treatment in one form or another. We have, therefore, been able to try it out on a wide variety of psychiatric conditions, and to come to some conclusions as to its value and its limitations.

The main technique we used, and the type of patient that responded so well, resulted from a fortuitous combination of therapeutic problems. Experimenting in 1939 with the use of light coma primarily in the treatment of depressions, we were

cut off from adequate sugar supplies in 1940. We considered substituting potatoes by liquefying them and putting them down a nasal tube. Then daylight bombing of the hospital during the Battle of Britain prevented us from going on with full coma for a while, and we had to let the patients eat the potatoes with a large breakfast just before dropping into coma. At that time there were numerous anxiety and hysterical states with severe weight loss in the hospital following the Dunkirk evacuation. We put some of them on this treatment as an experiment, and they started to show striking improvement in contrast to states of endogenous depression. We soon realized that we had found accidentally a simple technique of wide application to certain types of severe acute war neuroses. The subsequent widespread use of this treatment by both British and American armies, following our report, confirmed our findings and those of earlier workers along similar lines (3).

When we first published our results in 1941, however, we stressed the fact that the treatment had very real limitations. It could only restore the status quo of the individual, and it generally failed in that without the addition of other forms of treatment. The treatments combined with insulin were the exploration and abreaction of traumatic amnesic material, the use of sedation or narcosis, individual or group therapy; and it was important to procure a suitable environmental readjustment after the treatment was over, so that the patient did not face the same stresses, external and internal, that had caused his breakdown in the first place. Only in those who had lost many pounds in weight before starting to crack under their stresses did the treatment hold out hope that similar stresses might be better tolerated by the individual with his normal weight restored. Despite its limitations, the use of insulin has since become almost indispensable to us in the skilled treatment of many neuroses, simply because it often appears to supple-

<sup>1</sup> Read at the 104th annual meeting of The American Psychiatric Association, Washington, D. C., May 17-20, 1948.

<sup>2</sup> Visiting Professor of Neuropsychiatry, Duke University Medical School (1947-48). Physician in charge of Department of Psychological Medicine, St. Thomas's Hospital, London.

<sup>3</sup> Renamed Belmont Hospital under new National Health Service.



ment other therapies which might be less effective without it. For instance, one generally obtains a poorer result if a neurotic patient is allowed to return to work 30 pounds underweight even after other methods have been used correctly to treat his psychiatric problems.

We have experimented with several types of modified insulin treatment in the past 7 years. Generally we give the large morning dose alone; but when anxieties are very pronounced 2 and even 3 daily doses may be given, accompanied by the requisite food after each period of hypoglycaemia. We have also combined morning insulin treatment with a light narcosis for the rest of 24 hours. We have used this for the hyperacute anxiety states, or the early acute schizophrenic up to the time when he is approaching coma dosage. We have had no fatality directly due to any of these forms of modified insulin treatment in the past 7 years, despite the fact that 10 patients are often treated in several of the ordinary large wards of the hospital where 20 other patients may be having other types of treatment. Certainly such insulin treatments have proved to be among the safest in psychiatry, provided that ordinary common-sense nursing precautions are taken.

We ran a deep insulin coma unit side by side with modified insulin for the better part of 7 years in our neurosis centre, and so have been able to compare the relative clinical effects of these two therapies. And throughout the war we were permitted to keep a small proportion of ordinary civilian beds at Sutton to try out the effects of such treatments, developed in military cases, for their possible application to civilian treatment problems. We gradually became aware, therefore, of the uses and limitations of modified insulin techniques in the types of cases that we are now having to handle in peacetime.

In trying to arrive at conclusions about clinical indications we have avoided falling back on crude statistics, which can never assess all the detailed factors involved in the really skilled use of such treatments. Rather, we have tried to study as many patients as possible clinically—to see how the treatment has affected their individual symptoms, and

how best it could be fitted in with other treatment procedures necessary in the many varied types admitted for short-term intensive therapy as inpatients. So many factors enter into and influence the results of modified insulin that reliance on broad statistics can be most fallacious. I have already indicated that the successful treatment of a battle casualty, for instance, might often involve first the giving of front-line sedation, then an amytal or an ether abreaction or exploration, followed, perhaps, by a period of sleep treatment. Modified insulin might then be given to restore weight and reduce residual tension—and, when outstanding psychological problems had been dealt with by psychotherapy, the patient would be sent back to a job more in keeping with his potentialities. Every stage of such a treatment program can be minimized in its effect without the use of a previous or a subsequent one. Insulin will be used best in civilian cases when it forms a similar part of a broad totality of treatment. Its use in this way also requires what we should now demand from most psychiatrists, namely, a bedside working knowledge of many possible methods of approach in treatment, and their uses in the right combinations.

## RESULTS

*Psychoses.*—First I want to deal with some of the early recoverable psychoses, because there is now a growing tendency for this treatment to be used in such cases. I wish to express the personal opinion that those who are now substituting modified insulin treatment for a full insulin coma régime too often in early recoverable schizophrenia may be doing a very grave wrong to many patients. Schizophrenia in its treatable phase is too serious an illness, in its future consequences to any patient, to treat in a slipshod manner. We have found that modified insulin is no real substitute for coma treatment in the average run of early schizophrenic patients. Even if success is obtained treatment time is generally lengthened—the suffering of the patient is unnecessarily prolonged—and many may get a degree of deterioration added, even if they do partially remit at a later date. One can qualify this by saying, however, that modified insulin treatment is

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often better than no insulin at all, especially if electroshock is used concurrently. Some patients do well with this combination.

In the severe endogenous depressive psychoses we have found, generally, that insulin makes the patient feel worse rather than better. This is especially the case, I think, in the involuntional type of depression. This effect can often provide one of the indications for substituting electroshock for insulin, especially when such a patient begins to complain bitterly on the régime. Cases showing mixed anxiety and hysterical symptoms, on the other hand, are often appreciative of the treatment because they enjoy the relaxation afforded by the sweating and other autonomic effects of insulin; but the same autonomic effects only seem to increase the painful rumination and inhibition of the severe depressive, which may be relieved speedily by electroshock. Alternatively, the more neurotic and reactive types of depression, which may often be confused initially with endogenous ones, may be helped by the use of insulin when electroshock makes them worse. This response may also provide one of the diagnostic indications, among the many at our disposal, for separating these 2 groups of patients.

We have found that toxic confusional states may often be shortened by twice daily insulin dosage. The dose may have to be fairly large, so that the patient is starting to go into a light sopor when he is interrupted. We have used this method, for instance, to terminate confusional states following a course of continuous sleep, which might otherwise precipitate a neurotic patient temporarily and unexpectedly into a mental hospital.

*Neuroses.*—Turning to the neuroses—we are now seeing an increasing and unfortunate tendency to use this treatment as a complete treatment in itself. But it cannot be used against a patient's psychological resistance to recovery. Outstanding environmental and personal problems have to be dealt with at the same time, and the patient's future plans discussed. We have seen, for instance, hysterical patients, with big amnesic gaps, given insulin without any attempt to uncover and abreact a severe traumatic incident which may have precipitated or prolonged the illness. To use insulin in this way is generally

bad treatment. Weight may be put on, and the patient feels better temporarily, only to relapse fairly soon after the treatment is stopped. We have seen weight start to go up rapidly during insulin treatment, after traumatic incidents or pressing personal problems have been dealt with—then insulin has really helped to speed the patient's convalescence. Although psychotherapy may be the critical factor in bringing about the patient's improvement, and the patient would have recovered in time even if modified insulin treatment had not been given, yet a severe loss of weight and a persisting tension may more quickly respond under combined treatment, and so shorten the patient's illness and suffering.

Because of the necessity of using additional psychotherapy for many of their patients, some have felt that the effects of insulin treatment were themselves psychologically determined. The substitution of sterile water for a reasonable period will soon destroy this happy illusion in all but the most bigoted protagonists of psychotherapy, as will also the careful and prolonged observation of its effects in any large groups of mixed patients. I make this comment because one of your team of eminent American psychiatric experts, which arrived in Europe to investigate the problems of battle exhaustion with the fighting all but over, expressed the opinion, in a meeting at the Royal Society of Medicine, that the effects of such insulin treatments were largely psychological and abreactive. Others whom I have met in America have also expressed somewhat the same view—but I am sure that it is not the whole answer.

In civilian patients we are finding that the treatment has a more limited part to play in expediting recovery because cases of neuroses are less acute, and physical deterioration may not be so grave. But there are still many cases which can be helped. Time factors are most important in civilian treatment, especially in America where it is so costly to be sick. Whatever you do in the way of other treatments, the restoration of normal physique and the relief of tension afforded by insulin may help a patient to get back more quickly to his maximum efficiency, and creates greater confidence in other methods being used at the same time. Because of its

effect on tension and weight loss, it has been found useful in such conditions as postfebrile illnesses, gastric neuroses, hysterical vomiting, and certain types of 'colitis'—all psychosomatic states in which increasing interest is now being taken by internists and psychiatrists alike. It has also helped chronic asthmatics who have steadily deteriorated, lost large amounts of weight, and resorted to very large doses of adrenalin to combat their symptoms; a vicious circle may get broken up. General physicians, as a whole, are afraid of insulin in large doses, except in the treatment of diabetes; otherwise I am sure that this treatment, as a tonic and sedative in psychosomatic convalescence, would have far greater use today than it has.

I would like, finally, to call attention to one further possible use of insulin. Leucotomy is most successful in neurotic and psychotic conditions, where tension is a prominent feature. Cases of chronic, persistent tension, often accompanied by various other psychiatric symptoms, may be helped temporarily if large noncoma doses of insulin are given twice a day. Such patients may benefit permanently from leucotomy, provided that other factors are favorable, and when other treatments have failed. In a recently published case of chronic battle neurosis, treated finally with leucotomy when all other methods had failed, and thus rehabilitated to his old work of a printing machine operator—it was the temporary but pronounced relief obtained each day by large doses of insulin that helped us to arrive at a final decision to operate(4).

#### CONCLUSION

This brief résumé ends with one warning. Weir Mitchell developed a very successful treatment of neurosis in the American Civil War after he had observed that "those who had fought gallantly with Sheridan and Grant" could become "as hysterically emotional as the veriest girl" under continued loss of weight and wounds. Patients were greatly helped by his régime of rest, moral talks, heavy massage to the point of sweating, and enormous food intake (the same sort of effects that we now get with modified insulin techniques—but more easily).

He stressed that every part of the régime was dependent on other parts for its success. He laid down strict limitations of its use. It was so successful a treatment that for 25 years it enjoyed a world-wide vogue in peacetime practice—even greater than modified insulin today. But doctors gradually began to use isolated parts of the treatment for all types of psychiatric patients. They ceased to pick their cases carefully. Too much was expected of the treatment, and people saw inevitable relapses and failures. By 1925 the treatment was dead and buried, partly due to the increasing theoretical importance attached to the psychodynamic aspects of neurotic illnesses.

World War II showed us again the importance of attempting to treat, wherever possible, both the physiological and the psychological aspects of neurotic illnesses. A study of Weir Mitchell's indications for his treatment proved very similar to ours for modified insulin. But I fear that today history may repeat itself. Modified insulin has enormously increased in popularity because of some of its successes, and it is now too often used as a mere placebo for many unsuitable patients without reference to its precise indications and its many limitations seen in actual bedside practice. We shall have only ourselves to blame if it falls into total disrepute in a few years' time. Then in a third future war somebody else will have to rediscover Weir Mitchell's principles afresh, and try to emphasize again that good psychiatric treatment may often have to be multi-dimensional in approach, but must also be extremely selective in the methods and combinations of methods employed for different groups of patients.

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## AN ORTHOPEDIC AND NEUROLOGICAL FOLLOW-UP STUDY OF VERTEBRAL FRACTURES IN SHOCK THERAPY<sup>1</sup>

PHILLIP POLATIN, M.D., AND LOUIS LINN, M.D.

New York, N. Y.

### INTRODUCTION

Several years ago one of us (P. P.) (1, 2) reported the fact that compression fractures of the vertebræ were a frequent complication of shock therapy in the treatment of mental disease. This occurred in the course of metrazol therapy and in the course of insulin coma therapy when spontaneous convulsions occurred during this latter treatment. Although technical progress has diminished the incidence of these fractures very markedly, they still occur. Frequently one is faced with the problem of treating a recurrence of mental illness in the patient who had sustained a vertebral fracture in a previous course of treatment. Various questions consequently come to mind. What treatment do these injuries require? Are they associated with complications or sequelæ? Do they represent a contraindication to further shock treatment? An attempt to answer these questions will be made by this follow-up study occurring approximately 10 years after the original incidence of vertebral fractures. Emphasis was placed on orthopedic and neurological aftereffects.

### MATERIAL AND METHOD

A group of patients who sustained vertebral fractures during shock treatments administered in 1937 and 1938 was selected. Orthopedic and neurological examinations were performed on each patient available for this study. Roentgenograms of the spine were obtained where possible. Inasmuch as many of these patients were in state hospitals in a more or less disturbed condition, it was not always possible to obtain roentgenograms or to carry out the clinical examinations in detail. In each case where a follow-up x-ray

was obtained, this film was compared with that obtained at the time the original fracture occurred. On the occasion of the original injury, approximately 10 years ago, patients who complained of back pain were given aspirin or codeine symptomatically and a brief period of bed rest. No other orthopedic therapy was applied. Those who did not complain of back pain and who nevertheless manifested a fracture on x-ray examination received no treatment for the fracture whatever. In this report there is no attempt to evaluate the patients' present psychiatric condition or to indicate the effects of shock therapy on their mental condition.

### RESULTS

The pertinent material in summary form, pertaining to this follow-up study, is included in Table 1. The following observations were made approximately 10 years after the original injuries were sustained.

1. Of the 24 patients we were able to study, 13 complained of back pain at the time of the original injury. In the follow-up, 4 of these patients complained of occasional mild backache referable to the site of the injury. The other patients were asymptomatic as far as the back pain was concerned.

2. In all cases, neurological and orthopedic examinations were negative for any evidence of sequelæ following the original vertebral fracture.

3. Follow-up x-rays were obtained in 18 patients. In 15 cases these films showed no change over the original film, and this in spite of the fact that 6 of these patients had one or more courses of convulsive therapy after the original treatment during which the injury occurred. Three patients manifested some x-ray evidence of progression of the original lesion. Paradoxically, none of the patients manifesting this progression of the original lesion received further convulsive therapy after the injury.

<sup>1</sup> Read at the 104th annual meeting of The American Psychiatric Association, Washington, D. C., May 17-20, 1948.

From the Department of Clinical Psychiatry, New York State Psychiatric Institute.

TABLE 1

| Case No. | Name | Vertebra fractured in original convulsive therapy in 1937-38* | Complaints following injury | Follow-up x-ray studies in 1947  | Complaints on follow-up        | Orthopedic examination | Neurological examination | Subsequent treatment                          |
|----------|------|---|-----------------------------|--|--------------------------------|------------------------|--------------------------|---|
| 1        | G C  | T 6-7-8   | None                        | No change over original x-ray  | None                           | Negative               | Negative                 | None  |
| 2        | L C  | T 7-8   | Mild backache               | No follow-up x-ray   | None                           | Negative               | Negative                 | Received another course of ECT in 1946        |
| 3        | C G  | T 4-5-6-7-8   | Severe backache             | No change over original x-ray  | Mild backache occasionally     | Negative               | Negative                 | None  |
| 4        | M C  | T 5-6-7-8   | Moderate backache           | No follow-up x-ray   | None                           | Negative               | Negative                 | Received 3 additional ECTs in 1943            |
| 5        | J Q  | T 5-6-7-8-9-10-11-12  | Moderate backache           | General osteoporosis of thoracic spine. No other change over original x-ray  | None                           | Negative               | Negative                 | None  |
| 6        | F S  | T 5-6-7-8   | None                        | No change over original x-ray  | None                           | Negative               | Negative                 | Received 20 additional ECTs in 1942           |
| 7        | L W  | T 4-5-6-7   | Mild backache               | No change over original x-ray  | None                           | Negative               | Negative                 | None  |
| 8        | C G  | T 4-5-6   | Moderate backache           | No change over original x-ray  | Backache on strenuous exertion | Negative               | Negative                 | None  |
| 9        | S M  | T 5-6-7-8-9   | None                        | Slight anterior compression of T 5-6   | None                           | Negative               | Negative                 | Insulin treatment in 1941 with no convulsions |
| 10       | B S  | T 7-8-9   | None                        | No follow-up x-ray   | None                           | Negative               | Negative                 | Received course of insulin coma therapy       |
| 11       | A C  | T 4-5   | Moderate backache           | No change over original x-ray  | None                           | Negative               | Negative                 | None  |
| 12       | E L  | T 3-4-5   | Severe backache             | Slight anterior compression T 3-4-5; slight further compression of T 4; slight osteoarthritis of T 3-4-5   | Occasional backache            | Negative               | Negative                 | None  |
| 13       | M S  | T 7-8   | Moderate backache           | No change over original x-ray  | None                           | Negative               | Negative                 | None  |
| 14       | N P  | T 7   | Moderate backache           | No change over original x-ray  | Occasional backache            | Negative               | Negative                 | Received 6 additional ECTs in 1943            |
| 15       | S H  | T 5-6-7-8   | Moderate backache           | No follow-up x-ray   | None                           | Negative               | Negative                 | None  |
| 16       | D L  | T 5   | None                        | No change over original x-ray  | None                           | Negative               | Negative                 | None  |
| 17       | T O  | T 5   | None                        | No change over original x-ray  | None                           | Negative               | Negative                 | Received 19 additional ECTs in 1944           |
| 18       | R L  | T 5-6-7-8-9   | Moderate backache           | Slight anterior compression T 7-8  | None                           | Negative               | Negative                 | Received 20 additional ECTs in 1942           |
| 19       | N M  | T 4-5   | None                        | No change over original x-ray  | None                           | Negative               | Negative                 | Received 17 additional ECTs in 1946           |
| 20       | H O  | T 6-7-8   | Severe backache             | No change over original x-ray  | None                           | Negative               | Negative                 | None  |
| 21       | J C  | T 9-10-11   | None                        | No change over original x-ray  | None                           | Negative               | Negative                 | Received 43 additional ECTs in 1940           |
| 22       | M H  | T 4-5   | None                        | T 5 shows further wedging; T 3 and 4 now collapsed to former height; T 6 shows slight wedging-spur formations T 3 and 4; post-traumatic osteoarthritis | None                           | Negative               | Negative                 | None  |
| 23       | C S  | T 7   | None                        | No follow-up x-ray   | None                           | Negative               | Negative                 | None  |
| 24       | F W  | T 6-7   | None                        | No follow-up x-ray   | None                           | Negative               | Negative                 | Had 7 convulsions during insulin coma in 1946 |

\* The letter T and the number represent a compression fracture of the corresponding thoracic vertebra.

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These 3 cases are described as follows:

Case 5, a female patient, J.Q., showed X-ray findings, originally, of injury T 5-6-7-8-9-10-11-12. On the follow-up x-ray, approximately 10 years later, she manifested a generalized osteoporosis of the thoracic spine with no other changes present as compared to the original roentgenogram. This generalized osteoporosis may be related only to advancing age of the patient and not at all to the original thoracic injury. This is speculative.

Case 12, a female patient, E.L., manifested in the original x-ray some wedging of T 3-4-5. A follow-up x-ray, approximately 10 years later, showed slight anterior compression of T 3-4-5 with slight further compression of T 4 as compared to the original film; with slight osteoarthritis of T 3-4-5.

Case 22, a male, M.H., showed wedging of T 4-5 on the original roentgenogram. Follow-up films, taken approximately 10 years later, showed further wedging of T 5. In addition T 3 and 4 were now collapsed to two-thirds of their former height. T 6 manifested slight wedging. In addition there were osteoarthritic spur formations of T 3 and 4. Consequently, we see from this follow-up that T 3 and T 6, which were not previously involved, now show slight wedging.

None of these 3 patients received additional shock therapy following their original exposure about 10 years ago. These progressive changes in the pathological process of the 3 patients noted above were not associated with clinically evident disability or physical findings.

#### COMMENT

The aggravation of the vertebral fractures as observed in recent roentgenograms in the foregoing 3 patients must not be overlooked. One cannot say with certainty that these changes will not give rise to some disability in the future. However, in the follow-up study thus far, approximately 10 years after the original injury, it is indicated that whatever increase in the pathological process has taken place has proven to be benign from a clinical standpoint, *i. e.*, these changes have given rise to no complaints of pain and are without associated pathological orthopedic or neurological findings. In view of the roentgenological evidence of progression of the initial lesion in these 3 cases one might ask whether the vertebral fractures should not have been treated by immobilization in plaster. It is our feeling that the original opinion of our orthopedic consultant was

correct and that immobilization was not necessary. The incidence of progressive x-ray changes is small, 16%, and in none of these cases have these changes caused clinically evident disability. On the other hand, intensive treatment of a nondisabling orthopedic lesion could well give rise to a really disabling psychological problem.

It is a well-known fact that not infrequently patients who respond to shock therapy have a tendency to relapse at some later time. They must then be considered for another course of shock therapy. The follow-up study on the originally injured patients who received subsequent convulsive therapy is, therefore, particularly of interest to determine whether aggravation or progression of the original vertebral fractures occurs. In our series, where follow-up roentgenograms were obtained, 6 of these patients received a subsequent course of electroshock therapy, varying from 3 to 43 convulsions. None of these patients developed disabling symptoms or abnormal clinical findings, and none of these patients was in the group with increased pathological x-ray findings. Thus it can be said that these patients tolerated further convulsive therapy satisfactorily in spite of original pathology to the various thoracic vertebrae.

It may be noted here that no curare was used in the original convulsive therapy or in any subsequent exposure to convulsive treatment.

#### SUMMARY AND CONCLUSION

1. Twenty-four patients with vertebral fractures occurring during the course of convulsive therapy were studied approximately 10 years after the initial lesion.
2. Four patients complain of occasional mild, nondisabling backaches. The rest are symptom-free.
3. In no case is there clinical evidence of orthopedic or neurological sequelæ to the original injury.
4. In 3 cases x-ray findings indicate an increase in the original pathology involving the thoracic vertebrae.
5. Patients with vertebral fractures tolerate subsequent convulsive therapy satisfactorily.

6. No curare was used either in the original or subsequent convulsive therapy.

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#### DISCUSSION

DR. A. E. BENNETT (Berkeley, Calif.).—Drs. Polatin and Linn have rendered a valuable contribution and answered questions we all have asked ourselves, namely, how much permanent damage, disability or progressive pathology has occurred from convulsive shock compressive vertebral fractures. They have found a surprisingly low incidence of persistent symptoms and no evidence of chronic orthopedic or neurologic sequelæ. In a few instances they did find increase in the original pathology, but in the 10 years' follow-up no evidence of increased disability.

They have likewise answered the question as to whether intensive treatment or prolonged cast immobilization was necessary for their patients. In the early metrazol days before curarization technique was instituted, we did treat a few of these

cases by prolonged immobilization, but soon decided the advantages gained were not worth the psychologic and economic cost. After routine curarization protection of our patients we soon gave up all concern about the risks of skeletal injury. For the past 10 years we have had no traumatic complications.

I remember one insulin coma convulsive case that had a sufficiently severe spinal fracture to produce a permanent middorsal kyphotic deformity.

While Drs. Polatin and Linn give us the impression that vertebral fractures are of relatively little importance from the standpoint of permanent sequelæ, they have not mentioned extremity fractures. I am sure they would not want to leave the impression that humerus, femur, and scapular fractures are minor complications of treatment. These fractures have serious psychologic and physiologic consequences. Treatments have to be terminated, open reductions are often necessary, patients are disabled for long periods and often never regain full functional recovery. Some have suicided following these complications, and physicians have been sued for malpractice. These are extremely serious complications of straight metrazol or electroshock.

We still believe the treatment is not justified without the safeguard of preliminary curarization. No other safeguard so far has proved adequate to prevent all complications. Curarization, correctly given, does not increase the hazards of treatment; on the other hand it enables one to treat many patients who could not run the risk of straight convulsive shock. Its use should be routine if one wishes to avoid all risk of traumatic complications.

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# EFFECT OF ELECTROCONVULSIVE THERAPY ON WATER METABOLISM IN PSYCHOTIC PATIENTS<sup>1</sup>

M. D. ALTSCHULE, M. D., AND K. J. TILLOTSON, M. D.

Boston, Mass.

Convulsions induced electrically in the treatment of mental disease cause several types of change in water metabolism in psychotic patients. It is probable that these various changes are not all directly related to each other. During each seizure plasma is

(1, 2). The plasma volume measured by the Evans Blue Dye method falls as much as 35%, the average decrease being 15% (Fig. 1). These changes vary with the severity of

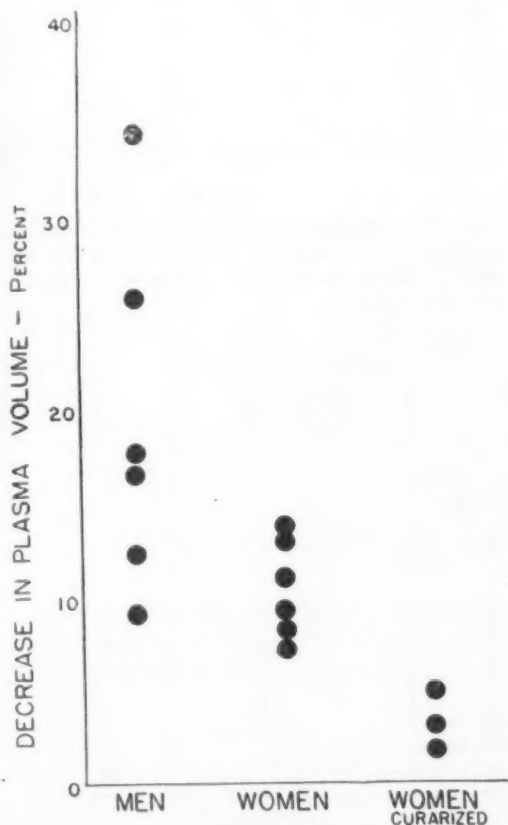


FIG. 1.—Decreases in plasma volume during electrically induced seizures.

lost from the circulation so that hemoconcentration occurs and plasma volume decreases

<sup>1</sup> Read at the 104th annual meeting of The American Psychiatric Association, Washington, D. C., May 17-20, 1948.

From the Clinical Services and the Laboratory of Clinical Physiology, McLean Hospital, Waverley, and the Departments of Medicine and Psychiatry, Harvard Medical School, Boston, Mass.

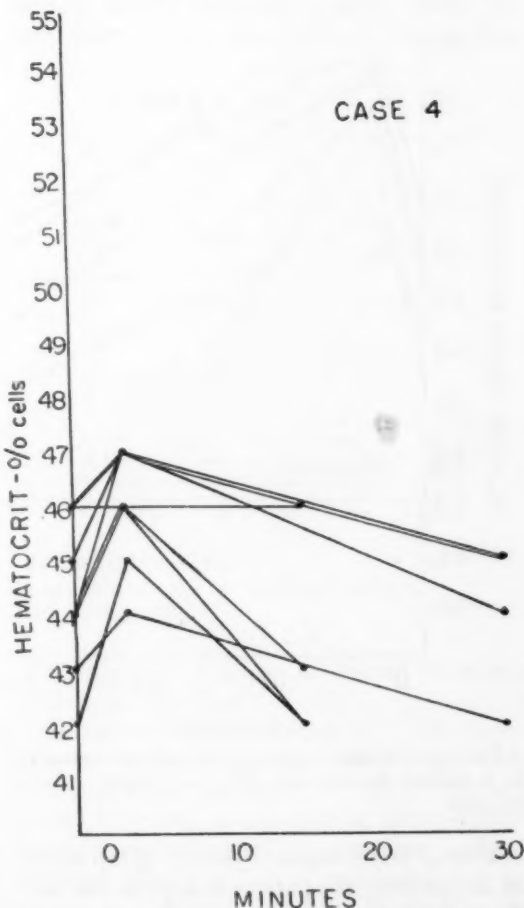


FIG. 2.—Changes in blood hematocrit level in a patient during and after electrically induced seizures.

the convulsion and are minimized by curarization (Fig. 1). The changes in hematocrit, plasma protein level, and plasma volume last less than half an hour (Fig. 2, 3). It is well known that loss of fluid from the circulation occurs in all types of muscular activity; the mechanisms involved include vasodilatation,

increased capillary pressure, changes in electrolyte concentration in the muscles, and other factors not yet understood(2). It is evident that hemoconcentration due to loss of fluid from the circulation is a side reaction and has no relation to clinical benefit derived from ECT.

A second phenomenon studied was the diuretic response to ingestion of water in psychotic patients before and after ECT(3). The test consists in having the patient, while

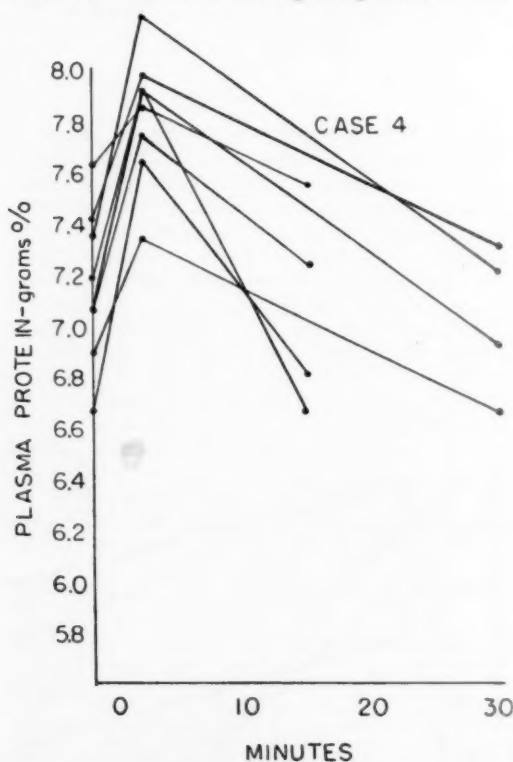


FIG. 3.—Changes in plasma protein concentration in a patient during and after electrically induced seizures.

in a basal state, ingest 1,500 cc. of tap water, in 20 minutes; the patient is kept in bed fasting for the next 5 hours. All urine spontaneously voided is collected and measured, the time being noted. Normal subjects excrete 1,500 cc. of urine in approximately 3 hours. Many untreated psychotic patients exhibit abnormal water diuresis. Depressed patients as a rule show retarded and decreased diuresis after ingestion of water (Fig. 4); some schizophrenic patients exhibit increased and/or accelerated responses (Fig. 5). Irrespective of the initial findings,

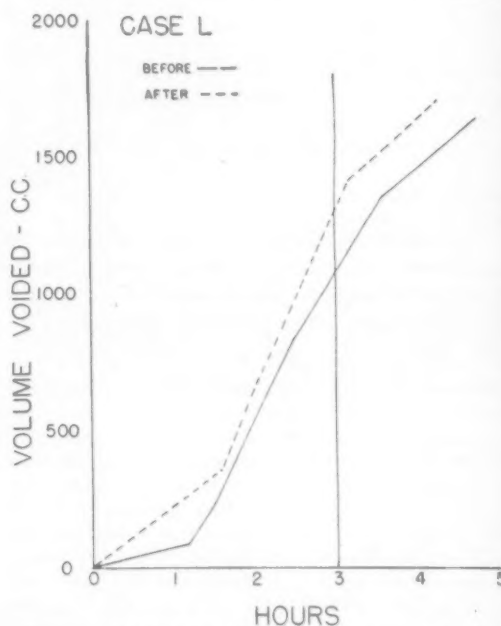


FIG. 4.—Diminished diuretic response following the ingestion of water in a depressed patient with return toward normal after a course of electroconvulsive therapy.

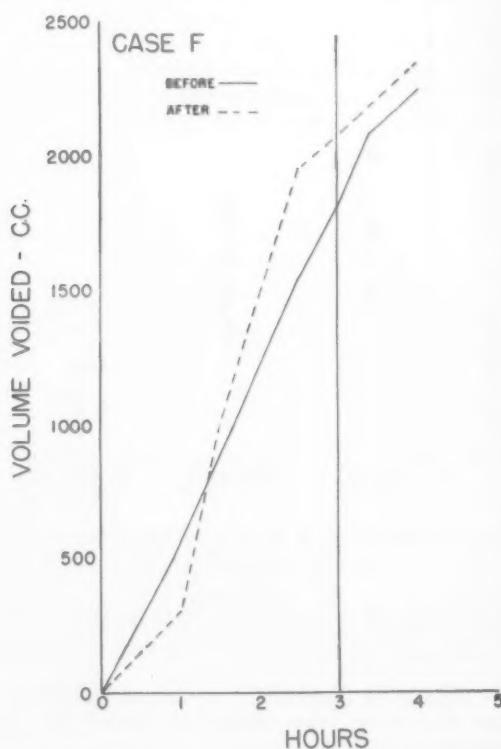


FIG. 5.—Increased diuretic response following the ingestion of water in a schizophrenic patient with further increase after a course of electroconvulsive therapy.



acceleration of diuresis occurs in patients who gain weight during the course of electroshock therapy. This finding resembles the effects of the action of some steroid hormones on water diuresis and accordingly may be interpreted tentatively as evidence that electroshock therapy results in increased secretion of such hormones.

Another change in water metabolism which occurs during the course of ECT is related closely to gain in weight. Measurements made by means of the thiocyanate method in depressed patients reveal lasting increases in the volume of extracellular fluid when

tained. These phenomena are indicative of the action of steroid hormones with ketone configuration at carbon 3. In patients who gain only a few pounds during the treatment, the gain in weight appears to be the consequence entirely of an increase in extracellular water (Fig. 6). When, however, larger amounts of weight are gained, increases in extracellular water are inadequate to account for the gain in weight; apparently an increase in intracellular constituents occurs in the body. Studies of nitrogen and electrolyte balance will be necessary to substantiate this impression; if so substantiated, this finding

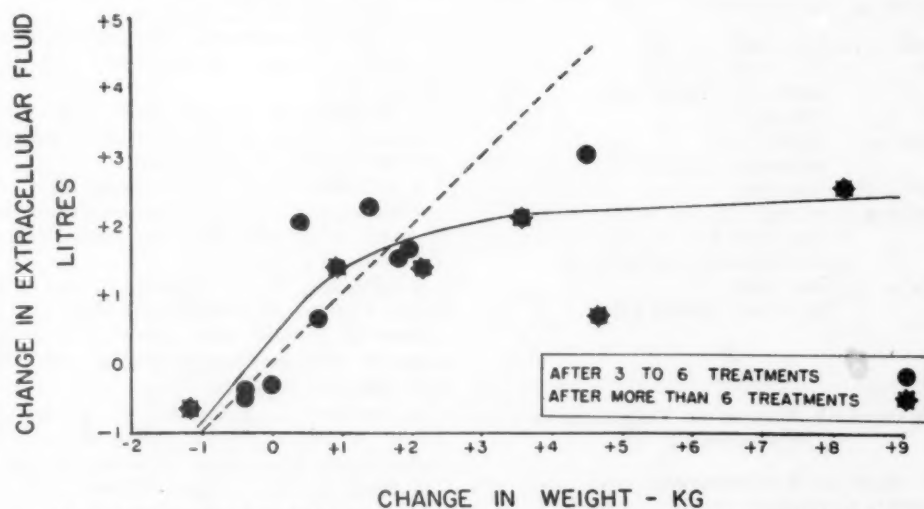


FIG. 6.—Changes in weight and in extracellular fluid volume in depressed patients following electroconvulsive therapy.

weight is gained rapidly after several treatments have been given (4). The blood sodium, however, is unchanged (Table 1); an

TABLE 1

SERUM SODIUM BEFORE ANY SHOCK AND AGAIN 24 TO 72 HOURS AFTER FOURTH OR FIFTH ELECTROSHOCK

| Case | Before | After    |
|------|--------|----------|
| 1    | 144.2  | 145.9 mE |
| 2    | 150.4  | 143.2    |
| 3    | 142.0  | 144.9    |
| 4    | 149.7  | 142.7    |
| 5    | 144.2  | 137.6    |
| 6    | 145.8  | 148.0    |
| 7    | 146.7  | 144.9    |

increase in extracellular fluid volume with no decrease in concentration of sodium indicates that both salt and water are being re-

will suggest the action of steroid hormones with anabolic effects.

In patients not receiving ECT, the injection of steroid hormones which cause only salt and water retention, *i.e.*, desoxycorticosterone, results in no clinical improvement in patients demonstrably responsive to shock therapy (Table 2). It is concluded that increase in extracellular water by itself is not the cause of remission of psychosis associated with ECT and that increased production of 3-ketosteroids is not essential for clinical improvement.

Apparently all the changes in water metabolism studied are side reactions and are not related causally to therapeutic benefit induced by ECT. Some of the findings here described are important, however, in that they indicate changes in the secretion of

steroid hormones. That there are effects of the action of steroid hormones other than, or additional to, salt and water retention is well known. It is of interest that one such hormone, *i.e.* testosterone, which has strong anabolic effects is known to cause remission of depressions (5, 6); in some patients it is possible to demonstrate that the effects of

mechanisms. Apparently increased secretion of 3-ketosteroids occurs in patients who show clinical benefit after shock; however, this is only a side reaction and is important only in pointing to the increased production of steroid hormones. That other effects of steroid hormones may be responsible for clinical improvement after shock therapy is suggested by available data. It is probable that the therapeutic effect of shock is reparative rather than destructive.

TABLE 2

FAILURE OF PROGESTERONE TO CAUSE REMISSION  
IN A PATIENT DEMONSTRABLY RESPONSIVE  
TO ELECTROSHOCK

*Case W. Female, 60. Involutional  
Psychosis: Melancholia.*

|              |  |
|--------------|--|
| Depressed    | .....Aug. 1946.                        |
| 6 shocks     | .....Dec. 1946.                        |
|              | Improved. Gained 4 lbs.                |
| Relapse      | .....Feb. 1947.                        |
| 12 shocks    | .....March 1947.                       |
|              | Improved. Gained 8 lbs.                |
| Relapse      | .....June 1947.                        |
| Progesterone | ..200 mg. I.M. and 120 mg. P.O. daily. |
|              | Sept. 28 to Oct. 11, 1947.             |
|              | Not improved. Gained 4 lbs.            |
| 9 shocks     | .....Dec. 1947                         |
|              | Improved. Gained 5 lbs.                |

TABLE 3

INTERCHANGEABLE EFFECTS OF TESTOSTERONE AND  
ELECTROSHOCK

*Case R. Male, 39. Psychoneurosis:  
Reactive Depression.*

|              |                                |
|--------------|--------------------------------|
| Depressed    | .....Aug. 1946.                |
| 5 shocks     | .....Dec. 10 to 20, 1946.      |
|              | Improved. Gained 8 lbs.        |
| Relapse      | .....Dec. 1946.                |
| 8 shocks     | .....Jan. 1 to 17, 1947.       |
|              | Improved. Gained 8 lbs.        |
| Relapse      | .....Jan. 1947.                |
| Testosterone | .....25 mg. b.d. Feb. 8 to 21. |
|              | Improved. Gained 6 lbs.        |
|              | Discharged.                    |
| Relapse      | .....May 1947.                 |

electroshock and of the administration of testosterone in large doses are interchangeable (Table 3). This finding suggests that the beneficial effects of shock therapy are reparative and that the destructive aspects of this type of therapy are side reactions.

#### SUMMARY AND CONCLUSIONS

Changes in salt and water balance in patients given ECT are mediated by various

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#### DISCUSSION

S. KATZENELBOGEN, M. D. (Washington, D. C.).—I fully agree with the authors that their study is important, notwithstanding their conclusion that the results obtained are "side reactions not related to clinical improvement." This study, in addition to other biochemical studies, contributes, at least, to tentative theories on the mode of action of the convulsive treatment.

Two types of changes in the water metabolism following treatment, namely, acceleration of diuresis and increase in the volume of the extracellular fluid, are taken by the authors as possibly indicative of the increase in the secretion of some steroid hormones. They arrive at this assumption because of the resemblance of their findings to the effect of the action of some steroid hormones. The authors wisely recognize that this hypothesis calls for further studies which would show more directly an actual increase in the secretion of the steroid hormones. But, I hasten to state, the hypothesis is

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welcomed by me inasmuch as it contributes to my understanding of the mode of action of convulsive therapy.

The other blood changes, namely, decrease in the volume of plasma and increase in proteins, are regarded as due to hemoconcentration caused by loss of fluid.

I shall discuss these and the other findings in connection with some of my own studies of the morphology and chemistry of blood before and within 1 to 1½ hour following individual electric shock treatments: We find increase in the white and red cells and the sedimentation rate in most, but not in all cases; also an increase in most of the chemical elements, but not in all; and where there is predominantly an increase, there is also, in a

relatively significant number of cases, a decrease. In the light of these findings I feel uncertain with regard to the authors' ascribing their blood changes entirely to hemoconcentration. To me, both the clinical reaction and laboratory findings indicate that on the physiological level convulsive treatment causes temporary but profound changes in the function and metabolism of organs. The findings of the authors and my own data show a tendency of organs and metabolism predominantly toward hyperactivity. One sees a similar tendency in nonspecific proteinotherapy.

I therefore venture to postulate that the mode of action, namely, activation of the function of organs attributed to nonspecific proteinotherapy, is equally applicable to nonspecific shock therapies.

# MYANESIN IN ELECTRIC SHOCK

## STUDIES IN RABBITS AND MAN<sup>1</sup>

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### INTRODUCTION

The rigor of a convulsion places such a strain on the cardio-respiratory, muscular, and osseous systems as to exclude a considerable number of patients from the possible benefits of electric convulsive therapy. Though the percentage of patients sustaining deleterious complications is small in a single course of unmodified convulsive therapy, a growing number of patients are receiving repeated courses of convulsive therapy with cumulative traumatic effects. The dose of muscle-paralyzing drugs now employed to eliminate convulsive rigor during electric shock therapy is so close to the fatal level that deaths have resulted, with a consequent refusal on the part of many therapists to employ these drugs. A drug which will modify convulsive rigor without appreciable danger is needed.

Berger and Bradley(1) in 1947 described the muscle-relaxing effect of  $\alpha$ : $\beta$ -dihydroxy- $\gamma$ (2methyl-phenoxy) propane which they named "myanesin." They suggested that the muscle-relaxing effect of this drug made it worth a clinical trial for the prevention of traumatic complications in electric shock convulsive therapy. This paper records the results of our investigation of myanesin in relation to electric shock convulsions.

### METHODS AND RESULTS

We studied the effects of myanesin in rabbits and man and its effects on the threshold and pattern of convulsion induced by electric shock. More than 100 observations were made on rabbits. Only a few observations were made on human subjects, because we quickly encountered complications. A series of in vitro experiments were then

undertaken in an effort to avoid the complications. The value of dilantin as a synergistic drug was tested.

### I. RABBIT EXPERIMENTS

Twelve rabbits varying in weight from 2.5 to 4.5 kg. were given 10% myanesin injections by ear vein. Several of these animals later received 8% and 5% myanesin solutions in aqueous urea. The several solutions used had the same neuromuscular effects for equivalent amounts of myanesin. Rapid (15 second) administration was more effective but was painful, so 24 injections were each given in approximately one minute.

Electric shocks were given with the Davis alternating current machine in the first 39 instances, in doses varying from 50 volts for 1/10 (the minimal dial setting) to 125 volts for 1/10 second. In order to get lower shock intensity for threshold stimulus determinations, we then used the Reiter rectified modulated stimulator (without commutator) in doses varying from 5 milliamperes to 100 milliamperes for periods lasting from 2/10 to 6/10 seconds. The electrodes were applied bitemporally.

#### A. Myanesin Effects in Rabbits

Doses of myanesin in amounts varying from 10 to 30 mg. per kg. of body weight had a mild sedative effect but when stimulated the rabbits moved about normally, albeit with less apparent fear or irritability. Doses of 50 mg. per kg. produced flaccidity, absence of righting movements, drooping of ears, and shallow fast breathing as previously described by Berger and Bradley(4). Movement of ears, forelegs, and head reappeared 2 or 3 minutes after the injection. At 2 to 6 minutes, the animals crawled, dragging their hind legs. After 5 to 10 minutes, behavior was normal. When 75 to 90 mg. per kg.

<sup>1</sup> Read at the 104th annual meeting of The American Psychiatric Association, Washington, D. C., May 17-20, 1948.

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was given, there were the previously described effects and the corneal reflex was abolished for 1 to 3 minutes. Respirations rose from 140 to 280 per minute, were shallow and diaphragmatic in character, and pulse rate increased. Cyanosis, slow breathing, and nystagmus occasionally appeared. Ataxic hopping returned after 2 to 9 minutes and behavior seemed normal 5 to 15 minutes following the injection. A dose of 80 mg. per kg., given 5 minutes after an injection of 50 mg. per kg., caused no more effect than 80 mg. per kg. given a normal animal.

#### *B. The Effect of Electric Shock in Rabbits*

Fifty-volt stimulation for 1/10 second with the Davis alternating current machine caused immediate extensor spasm lasting 10 to 20 seconds, followed by clonic kicks for 5 to 15 seconds, then relaxed posture for the next 25 to 35 seconds. There was a return of normal posture and activity 1 to 10 minutes after the convulsion, successive seizures or shocks much above threshold requiring a longer recovery period. The usual threshold stimulus with the Reiter rectified current stimulator was 20 to 30 milliamperes for 0.4 to 0.5 sec. (commutator off) and the seizure pattern was the same as described for the Davis machine. If succeeding shocks were given 2 minutes apart, the convulsive threshold was raised 100%. When the time between shocks was 10 minutes, little increase above the threshold stimulus was needed to elicit a strong fit.

#### *C. Effects of Electric Shock in Rabbits after Myanesin*

Myanesin increases the threshold for a convulsive electric shock and modifies the fit pattern. When first given 17 mg. per kg. of body weight, a dose without observable muscular effect, an electric stimulus of 50 volts for 1/10 second with the Davis machine caused strong clonic movements for 5 seconds, then 5 seconds of limp narcosis, a few kicks, and then recovery 20 seconds after a stimulus which was above the normal tonic-clonic seizure threshold.

When given 50 mg. per kg., followed in 2 minutes by 50 volts for 1/10 second, the animal merely kicked once and lay still for

a minute or made a few jumping movements without progression. When given 60 mg. per kg. followed by 75 volts for 1/10 second promptly with the onset of deep paralysis, no response whatever was observed. When 125 volts for 1/10 second was given 3 minutes after the injection of myanesin (as paralysis began to clear) a single vigorous kick resulted. Repetition of the 125-volt shock at 15-minute intervals gave confusion with running into the wall but no tonic fit until more than an hour after the injection. When 75 mg. of myanesin per kg. were followed in 3 minutes by 100 milliamperes for 0.2 second with the Reiter machine, only a running movement resulted. A rabbit given 90 mg. of myanesin per kg. followed in 2 minutes by 75 volts for 1/10 second had a clonic seizure.

No animal given myanesin in the amounts used had a tonic seizure though the stimulus was as much as 4 times that normally required for such a seizure. A shock above normal threshold may be without muscular effect only if given immediately with the onset of severe paralysis that follows in variable degree from doses of 60 to 90 mg. per kg.

## II. OBSERVATIONS IN MAN

### *A. The Effects of Myanesin in Human Subjects*

CASE 1.—A 60-year-old male, depressed and restless for a year, was given 10 mg. of myanesin per kg. of body weight. The 10% solution ampule available(10) was diluted with 2 volumes of distilled water and the intravenous injection took 3½ minutes. No effect was observed on reflexes, strength, coordination, speech, or pulse. Blood pressure had risen from 134/84 to 142/94 three minutes after completion of the injection and fell to the initial level in 10 minutes. Twenty minutes after the injection the subject had fallen asleep.

An hour after the first injection the patient was awakened and given a further injection of 22 mg. of myanesin per kg., intravenously in the space of 6 minutes. Flushing of the face and neck was apparent and the patient reported feeling hot in his head. At the end of this injection there was considerable drowsiness and some neck muscular weakness. The dynamometer showed a hand grip strength decrease of 22%. Blood pressure, which was 130/92 at the beginning of the second injection, fell to 122/88 midway during the injection and rose to 136/94 eight minutes after the injection was completed.

Three weeks later he received 40 mg. of myanesin per kg. of body weight in 10% solution in the course of 10 minutes. He complained of some arm pain during the injection. Blood pressure rose from 138/90 to 150/90. Flushing was followed by drowsiness and a 10% decrease in hand grip strength. The electrocardiogram was unchanged but the EEG showed a slowing of the alpha rhythm from 10-12 per second to 8½ per second.

CASE 2.—A 28-year-old Negress with hysterical tremor of the right leg was given 10 mg. of myanesin per kg. of body weight in 7 minutes intravenously. The preparation used(11) was a 5% ampule solution in aqueous urea further diluted with 4 volumes of distilled water. The patient experienced mild warmth, nausea, and nystagmus. Tremor, reflexes, sensation, and coordination were unaffected. Twelve minutes after the first injection the same amount was again given in the space of 3 minutes. The previous symptoms were more intense but the patient felt relaxed. Nystagmus was still apparent after 40 minutes and tremor was unaffected.

CASE 3.—A 61-year-old male, with agitation and somatic delusions of several years' duration, was given 6 mg. of myanesin per kg. of body weight intravenously. The 5% ampule solution was diluted to 1% with physiological saline. No clinical effect was demonstrated. Two weeks later he was given 12 mg. per kg. Blood pressure fell from 170/110 to 156/96 and drowsiness was marked. Nystagmus was still evident when awakened after 20 minutes but was absent at the end of an hour.

#### *B. Effect of Electric Shock in Man after Myanesin*

The first of our 3 subjects (Case 1 above) received an electric shock from the Reiter machine 10 minutes after the second of 2 injections of myanesin which totalled 32 mg. per kg. of body weight. With the commutator on, the usual threshold convulsive dose is 10 milliamperes for 1 to 3 seconds. The patient's first shock was 12 milliamperes for 3 seconds. The only effect observed was blinking and tensing of all skeletal muscles during the stimulation. This stimulus was promptly followed by 16 milliamperes for 4 seconds. The hand treatment switch of this machine permits the experienced operator to stop the stimulation at the first visible sign of the convulsive pattern. After 4 times the normal duration of stimulus necessary at this setting, the patient had an apparently unmodified strong tonic-clonic seizure with uneventful recovery.

#### *C. Synergistic Effect of Myanesin with Dilantin*

Toman(12) has reported that near toxic doses of dilantin eliminate the tonic phase of the electric shock convulsion. As this same phenomenon was seen in rabbits given subparalyzing doses of myanesin before electric shock, we used both drugs together in a human subject before electric stimulation.

Case 3 (the 61-year-old depressed man) was given 0.1 gram of dilantin 4 times daily and on the 5th and 7th days he was given an electric shock treatment of 80 volts for 0.2 second with the Davis machine. He had a mild clonic seizure followed by amnesia after each stimulation. On the tenth day his third shock was preceded by 24 mg. of myanesin per kg. administered intravenously in 6 minutes. The patient walked from his bed to the shock treatment table without unsteadiness and was less apprehensive than usual. He was then given 100 volts for 0.3 second. The only movements observed were trembling of the closed eyelids and upward rolling of the eyes. Apnea was apparent for about 40 seconds but no cyanosis appeared and no treatment of the apnea was necessary. Unconsciousness was complete for 2 minutes. Recovery thereafter was uneventful and quite similar to the sequence seen after a strong clonic-tonic fit. He had a definite amnesia. Ten minutes later he was alert, asking the usual orienting questions. The sought-for elevation of mood appeared following this treatment and persisted through the next 2 days. On the twelfth day he was given an electric shock but only dilantin was used. On this occasion he had a strong unmodified seizure 2 minutes after 100 volts for 0.3 second though the dilantin dose had been raised 50%.

### III. COMPLICATIONS

#### *A. Complications in Rabbits*

Four rabbits died during our experiments. The first two deaths were immature (2.5 kg.) animals given 2 seizures and then 100 mg. of myanesin per kg. intravenously in 15 seconds. Failure of respiration was immediate. Artificial resuscitation was attempted manually without success. The next 2 deaths

were animals given 75 mg. of myanesin per kg. intravenously in 15 seconds. The first death occurred 1 hour later. The second death occurred 2 hours later. Rabbits given 100 mg. of myanesin per kg. intravenously in 15 seconds and then 100 mg. of dilantin per kg. intravenously in 15 seconds died 1 hour later.

#### *B. Complications in Man*

On our first case, the patient was given 10 mg. of myanesin per kg. of body weight in 7 minutes intravenously. The preparation used(11) was a 5% ampule solution in aqueous urea further diluted with 4 volumes of distilled water. The patient experienced mild warmth, nausea, and nystagmus. Tremor, reflexes, sensation, and coordination were unaffected. Twelve minutes after the first injection the same amount was again given in the space of 3 minutes. The previous symptoms were more intense but the patient felt relaxed. Nystagmus was still apparent after 40 minutes and tremor was unaffected.

In our second case, the patient was given 6 mg. of myanesin per kg. of body weight intravenously. The 5% ampule solution was diluted to 1% with physiological saline. No clinical effect was demonstrated. Two weeks later he was given 12 mg. per kg. Blood pressure fell from 170/110 to 156/96 and drowsiness was marked. Nystagmus was still evident when awakened after 20 minutes but was absent at the end of an hour.

#### IV. MYANESIN

A number of rabbits were taken in the course of our experiments. The first two deaths were immature (2.5 kg.) animals given 2 seizures and then 100 mg. of myanesin per kg. intravenously in 15 seconds. Failure of respiration was immediate. Artificial resuscitation was attempted manually without success. The next 2 deaths

were animals given a series of a dozen electric shocks of increasing intensity and then given 75 mg. of myanesin. One died of immediate respiratory failure and the other died several hours later.

Rabbits that received 10% myanesin solutions all had thrombosis of the veins of the injected ear with resultant dry gangrene.

#### B. Complications in Man

On our third intravenous injection of myanesin in Case 1, we used the undiluted 10% ampule solution (10) and at once the patient complained of arm pain. There was some slight constriction about the upper arm noted soon after the injection began but it was apparent at the end of the injection that the entire visible venous system of the injected arm was becoming thrombosed. The myanesin entered the general circulation as was apparent from the flushing, drowsiness, and nystagmus. The thrombosis prevented our shocking the patient. There was no febrile response or systemic symptom and the condition cleared with conservative measures.

In our second case hemoglobinuria was encountered, though a 1% myanesin solution was employed as recommended by Pugh and Enderby (8). The peak of hemoglobinuria was over by the 12th hour but a positive benzedine was still obtained on urine voided 16 hours after the injection.

#### IV. MYANESIN EFFECTS ON BLOOD IN VITRO

A number of hemolysis studies were undertaken in the hope that a solvent might be found that would permit small volume injections without hemoglobinuria. Ethyl alcohol, urea, and propylene glycol dissolve myanesin readily in contrast to its low (1.09%) solubility in water. Concentrated solutions in all solvents tested proved hemolyzing. Preparations of myanesin added to oxalated or citrated blood in vitro produced a chocolate-colored flocculant when the ratio of myanesin to blood was greater than 1:70 and no trace of hemoglobin remained by spectroscopic examination. If added myanesin is stronger than 1%, hemolysis is produced even though the ratio of myanesin to blood is as low as 1:2000. Provided myanesin is buffered by physiologic saline solution

and is not above 1% strength, no hemolyzing effect is noted even in the routine hypotonicity blood fragility test.

#### V. DISCUSSION

Myanesin does have muscle-relaxing effects in man as was first reported by Mallinson (2) in 1947. He employed it successfully to obtain muscle relaxation during light anesthesia in 112 surgical patients. Ballantine (3) in 1948 reported that 9% of his 76 operative anesthesia cases experienced reduction in depth of respiration. He found that the muscle-relaxing effects vary from person to person. One gram of myanesin in 10% solution given intravenously together with 0.5 gram of thiopentone caused muscle relaxation for 5 minutes in one case and for 2½ hours in another, whereas one patient showed no effect from twice this amount.

The most alarming complications are not necessarily immediate. Hewer and Woolmer (5) reported a death due to renal failure 6 days after operation and considered myanesin implicated. A fall in blood pressure to 70 mm. of mercury occurred 10 minutes after the last of 3 myanesin injections that totalled 56 mg. per kg. of body weight. Vomiting during the next 4 days was followed by granular urinary casts, hematuria, a blood urea of 290 mg., and death. Necropsy showed active erythropoiesis in the bone marrow. The collecting tubules showed impacted brownish granular material as is seen after incompatible transfusion or severe anoxic kidney damage. The combination of drugs and procedures to which the unfortunate patient was subjected obscured the effect of myanesin but the importance of its role is reinforced by the observation of Stephen (6). He reports that a subject given 30 mg. of myanesin experienced constant severe retching for 4 to 5 days together with marked hemoglobinuria and oliguria. Ballantine (3) reported syncope in one case and Stephen and Chandy (7) reported syncope in one of their patients after only 0.2 gram of myanesin.

Pugh and Enderby (8) were the first to report the hemolyzing effect of myanesin after encountering it in several of their operative patients. They found hemoglobinaemia



occurred in every administration of 10% myanesin. Stephen and Chandy(7) found hemoglobinuria in 40% of their administrations of 10% myanesin by the intravenous route, urinary discoloration continuing up to 8 hours. These workers noted that many of their subjects had thrombosis of the injected vein which in several instances spread rapidly to the shoulder, requiring ligation of the thrombosed vein.

The greater safety of more dilute solutions was first suggested by Pugh and Enderby (8), after the following observation. Antecubital venous blood, taken during wrist vein injection of 1% myanesin in the same arm, showed no hemolysis, whereas 5% and 10% myanesin injection did produce hemolysis in the proximal blood sample.

That near lethal doses of myanesin are necessary to block nerve-muscle preparation responses to electrical stimulation was first pointed out by Berger and Bradley(4) in 1946 but these workers considered the mean paralyzing dose to be only one-third of the mean lethal dose in the intact animal. Yet, they reported deaths of rabbits rapidly given 100 mg. of myanesin per kg. of body weight. They considered rabbits given 50 mg. per kg. as paralyzed upon finding loss of righting reflexes. We found vigorous muscular responses to electric stimuli returned within 2 minutes of termination of an injection of 50 to 90 mg. per kg., though paralysis was thought to be still present. Stephen and Chandy(7) found that myanesin gave depression of nerve and muscle action potentials at levels of 50 mg. per kg. in cats and complete absence of movement and action potentials at 70 mg. per kg., but the animals died from levels of myanesin above 60 mg. per kg. body weight. They found that in cats unresponsiveness to painful stimuli required 5/6 the minimal lethal dose. Complete paralysis with electrical unresponsiveness requires dangerously high levels of myanesin in vertebrates and we, therefore, avoided reaching high levels in human subjects.

The neurologic findings which we encountered in human subjects have been reported by Stephen and Chandy(7) and Berger(9).

We wish to caution those employing myanesin to test the hemolyzing and thrombosing effects of the preparation employed. When

used it should be administered in 1% strength in physiologic saline intravenously. Truly paralyzing doses are near the level causing respiratory failure and syncope. It has definite effects on the central nervous system, even moderate doses causing nystagmus and sedation. It is hoped that chemists will so modify its properties as to permit hypodermic administration of convenient volumes without blood destruction and yet retain its paralyzing action with an increased safety margin. We hoped that the tonic phase of the convulsion would be eliminated in man as it was in the rabbit at safe levels, but this did not occur until dilantin was added.

### CONCLUSION

Myanesin produces muscle relaxation and reversible paralysis.

Small doses of myanesin greatly modify the response to electric stimulation in the rabbit. The convulsive threshold, in rabbits, is raised and the tonic phase eliminated for periods up to an hour. Large doses of electric current are without observed effect if given just as myanesin paralysis sets in. Within 2 minutes after myanesin injection muscular response to strong electric stimulation returns. The margin of safety between a paralyzing dose and a lethal dose is relatively small.

In man, myanesin also raises the convulsive threshold to electric shock but moderate doses of myanesin do not prevent a strong, tonic-clonic seizure. Myanesin should be injected intravenously only in 1% solution in physiologic saline if hemolysis is to be avoided. Because of its complications, myanesin alone is not recommended for practical use to soften the convulsive rigor in electric shock convulsions in man. Dilantin enhances the ability of myanesin to soften convulsive rigor. The combined use of myanesin and dilantin warrants further trials.

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# A NOTE ON THE VALIDITY OF WECHSLER-BELLEVUE SCATTER

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## INTRODUCTION

Sufficient evidence has been accumulated to make probable the supposition that psychological deficit as measured by psychological tests is a concomitant of psychological or so-called functional disturbances (4). The history of attempts to relate Wechsler-Bellevue performance and psychiatric nosological categories has had several recent reviews (4, 5, 6, 7, 8), and we shall not consider it here except to note that the work of Rapaport (6) indicates that extent of scatter on the Wechsler-Bellevue parallels the severity of psychological disturbance. Recent papers by Gilliland (3), Garfield (2), and Foster (1), however, throw some doubt on the validity of Rapaport's findings and the use of Wechsler-Bellevue scatter in general.

In the present study we shall attempt to show that an empirically derived index score as a measure of scatter on the Wechsler-Bellevue test is a valid indicator of psychological disturbance and, further, in agreement with Rapaport, suggest that the extent of scatter roughly parallels the extent of psychological disturbance.

## THE PRESENT STUDY

Rapaport (6) reports Wechsler-Bellevue subtest scores and other pertinent data on over 200 cases. Using these data, differences between various Wechsler-Bellevue subtest scores were computed to discover which differences formed an increasing progression from the normals to the most seriously ill as determined by psychiatric diagnosis. Four differences were found which met this criterion as follows: (1) information minus comprehension; (2) block design minus digit symbol; (3) vocabulary minus picture completion; and (4) absolute difference between similarities and block designs. These differences were summated to give an index score.<sup>2</sup>

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<sup>2</sup> Negative numbers were not counted, *e.g.*, information must have a higher weighted score than comprehension to yield a difference score.

Since the Wechsler-Bellevue subtests have been statistically equated, the theoretical expectation is that, for a given individual, subtest scores should be equal. On this assumption, therefore, the index score calculated as indicated above represents a deviation from normal expectancy for the subtests used. Little in the way of theoretical considerations guided the choice of subtests making up the index score. Systematic search through a given experimental population indicated the validity of the index for that population. These data will now be presented.

Index scores were calculated for 49 normals, 75 neurotics, 28 acute psychotics, 23 chronic psychotics, 23

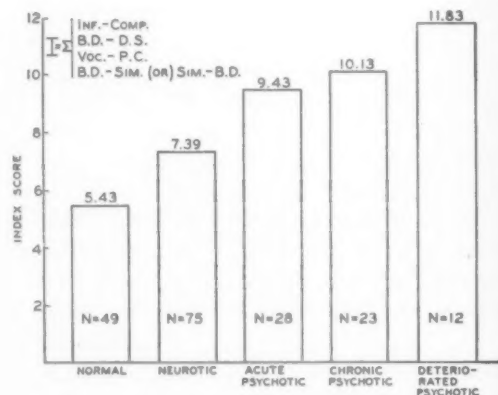


FIG. 1.—Relationship between index score and psychiatric diagnosis.

chronic psychotics, and 12 deteriorated psychotics as reported by Rapaport (6). Fig. 1 shows the results obtained. The differences between mean index scores for the various nosological groups were tested for significance by the "t" test. Table 1 shows the results obtained. The difference between "normals" and psychiatric patients is statistically significant, and neurotics are significantly differentiated from psychotics. It is felt that the observed differences can be attributed neither to age nor to education, since no significant differences were found between groups with respect to these variables.

If the thesis is accepted that the arrange-

ment of nosological groups along the base line of Fig. 1 represents a rough progression from less to more psychological disturbance, these findings can be taken as evidence of the correspondence between Wechsler-Bellevue scatter and extent of psychological disturbance for Rapaport's population. A crucial test of the validity of the index score, however, rests on the demonstration of its differentiating power for a second and different experimental population. With this thought in mind the index score was now

including the deteriorated psychotics) from Rapaport's population (see Table 2). These findings attest to the reliability of the index score as a correlate of extent of disturbance.

Further analysis of the Butler Hospital data showed no significant difference between inpatient neurotics and inpatient psychotics. To provide a crucial test of the validity of the index score as an indicator of level of adjustment, all the patients of the Butler Hospital population diagnosed neurotic were divided into 2 groups—those

TABLE 1

P VALUES FOR DIFFERENCES BETWEEN GROUP MEANS OF FIG. 1

|                              | Normal | Neurotic | Acute psychotic | Chronic psychotic | Deteriorated psychotic |
|------------------------------|--------|----------|-----------------|-------------------|------------------------|
| Normal .....                 | ...    | .01      | .01             | .01               | .01                    |
| Neurotic .....               | ...    | ...      | .03             | .01               | .01                    |
| Acute psychotic .....        | ...    | ...      | ...             | .55               | .30                    |
| Chronic psychotic .....      | ...    | ...      | ...             | ...               | .48                    |
| Deteriorated psychotic ..... | ...    | ...      | ...             | ...               | ...                    |

TABLE 2

THE EXPERIMENTAL POPULATIONS

| Rapaport's population         | N  | Mean age | Mean educ.<br>in grades | Mean index<br>score | S. D.<br>index score |
|-------------------------------|----|----------|-------------------------|---------------------|----------------------|
| Normals .....                 | 49 | 35       | 12.3                    | 5.43                | 3.47                 |
| Neurotics .....               | 75 | 37.7     | 13.2                    | 7.39                | 3.47                 |
| Acute psychotics .....        | 28 | 31.4     | 13.2                    | 9.43                | 4.49                 |
| Chronic psychotics .....      | 23 | 29.6     | 13.1                    | 10.13               | 3.78                 |
| Deteriorated psychotics ..... | 12 | 38.3     | 13.6                    | 11.83               | 7.28                 |
| Butler Hospital population    |    |          |                         |                     |                      |
| Inpatients * .....            | 53 | 32.8     | 12.13                   | 9.74                | 4.76                 |
| Outpatients † .....           | 66 | 28.5     | 11.4                    | 7.22                | 3.43                 |
| Psychotics .....              | 43 | 31.0     | 12.7                    | 9.92                | 4.67                 |
| Neurotics .....               | 76 | 30.1     | 11.1                    | 7.88                | 3.44                 |
| Inpatient neurotics .....     | 12 | 37.3     | 11.7                    | 10.00               | 4.12                 |
| Outpatient neurotics .....    | 64 | 26.5     | 11.0                    | 7.32                | 3.50                 |

\* 41 psychotics and 12 neurotics.

† 64 neurotics and 2 psychotics.

applied to randomly selected groups of Butler Hospital patients.

For a first estimate, index scores were applied to the Wechsler-Bellevue records of 53 inpatients and 65 outpatients. The inpatients obtained a mean index score of 9.7 and the outpatients a mean index score 7.2, a difference significant at the 1% level of confidence. It should be noted that the mean index score of the Butler Hospital neurotic outpatient group corresponds very closely to the mean obtained from Rapaport's neurotic group. A similar correspondence obtains between the Butler Hospital largely psychotic inpatient group and a comparable group (ex-

cluding the deteriorated psychotics) from Rapaport's population (see Table 2). These findings attest to the reliability of the index score as a correlate of extent of disturbance. Further analysis of the Butler Hospital data showed no significant difference between inpatient neurotics and inpatient psychotics. To provide a crucial test of the validity of the index score as an indicator of level of adjustment, all the patients of the Butler Hospital population diagnosed neurotic were divided into 2 groups—those

Table 2 summarizes the data of this study. With respect to the practical use of index scores it should be noted that their vari-

ability, as reflected in their standard deviation, is high. In addition, this study used only 7 of the 11 subtests. The problem of the practical use of Wechsler-Bellevue scatter is elsewhere discussed (5, 6, 7, 8).

#### SUMMARY AND CONCLUSIONS .

It is concluded (1) that the index score as a measure of Wechsler-Bellevue scatter empirically derived for this study shows a significant difference between normals (not patients) and neurotics, and between neurotics and psychotics; (2) that an estimate of progressive seriousness of psychological disturbance based on psychiatric diagnosis is reflected in an increased index score for 2 separate hospital populations; and (3) that the index score is an estimate of level of adjustment as evidenced by its ability to discriminate significantly between inpatient neurotics and working outpatient neurotics.

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# THE INCIDENCE OF ALLERGY IN PSYCHOTIC REACTIONS<sup>1</sup>

ROBERT M. McALLISTER, M.D., AND ARTHUR O. HECKER, M.D

Coatesville, Pa.

It has been a frequently and informally expressed observation by those who have practiced in large psychiatric hospitals that the incidence of allergic manifestation among psychotic patients is less than among the normal population. Two surveys of psychotic patients for allergic phenomena have been made previously. MacInnis(1) did a preliminary study in 2 psychiatric hospitals of 3,500 patients each in 1936. She reported 5 cases with symptoms of allergy among 7,000 patients, an incidence of 0.07%. A second survey by Leavitt(2), in 1943, revealed 10 cases of bronchial asthma among 11,647 patients with a primary diagnosis of a functional psychosis, an incidence of 0.08%. Neither of these surveys was complete, nor were controls used.

The present investigation was planned to determine whether it could or could not be shown by the use of both objective and subjective phenomena and control cases that the incidence of allergy among psychotic patients varied from that of a normal group of individuals. For this survey, 1,875 hospitalized neuropsychiatric patients were used as a test group. The control group consisted of 757 persons employed by the same hospital in which these patients were resident. This control group was believed to constitute a valid sample of the general population for the geographical area. In order to achieve uniformity between the control group and the patient group, the survey was done at a time when a specific allergen (ragweed pollen) was a common circumstance of the environment for both patients and controls.

## METHODS

A pollen-counting apparatus was constructed and placed in the most suitable spot for collecting pollen during the period of

the survey. The pollen-counting chamber and pollen-counting techniques were those recommended by the National Pollen Survey Committee of the American Academy of Allergy. Daily pollen counts were taken during the period of the survey. These were compared with daily pollen counts reported in 2 Philadelphia newspapers (Table 1). The location of our pollen-counting chamber

TABLE 1

### POLLEN COUNTS

| Controls<br>examined | Coatesville<br>Veterans<br>Hospital | Philadelphia<br>Bulletin | Philadelphia<br>Inquirer |
|----------------------|-------------------------------------|--------------------------|--------------------------|
| Aug. 18, 1947        | 6.4/cm. <sup>2</sup>                | 5.0/cm. <sup>2</sup>     | 3.6/cm. <sup>2</sup>     |
| 19                   | 6.4                                 | 7.5                      | 8.6                      |
| 20                   | 2.8                                 | 4.3                      | 3.1                      |
| 25                   | 17.4                                | 10.5                     | 12.0                     |
| 26                   | 33.1                                | 14.2                     | 14.7                     |
| 27                   | 14.1                                | 13.6                     | 14.1                     |
| 28                   | 17.3                                | 16.2                     | 7.5                      |
| Sept. 2              | 42.9                                | 18.7                     | 60.0                     |
| 3                    | 39.6                                | 27.0                     | 40.0                     |
| 4                    | 34.0                                | 44.0                     | 38.4                     |
| Patients<br>examined |                                     |                          |                          |
| Sept. 8              | 12.2                                | 14.2                     | 24.0                     |
| 9                    | 18.0                                | 29.8                     | 23.2                     |
| 10                   | 16.1                                | 8.1                      | 25.6                     |
| 11                   | 18.4                                | 9.0                      | 11.1                     |
| 15                   | 25.0                                | 13.6                     | 24.1                     |
| 16                   | 14.7                                | 11.2                     | 18.4                     |
| 17                   | 15.9                                | 5.6                      | 14.7                     |
| 18                   | 7.4                                 | 4.3                      | 2.5                      |
| 22                   | 4.9                                 | 1.9                      | 1.1                      |
| 23                   | 1.4                                 | 2.5                      | 2.5                      |
| 24                   | 1.0                                 | 3.8                      | 2.2                      |

was approximately 40 miles from the Philadelphia area, in a rural setting.

Patients and personnel were surveyed by a dual method: (A) Allergic history; (B) Direct examination of the conjunctiva, nasal and nasopharyngeal mucous membranes, chest, and skin.

## EXAMINATION

1. *Personnel.*—Personnel were scheduled so that they could be examined in groups of 10 by a specially trained team consisting

<sup>1</sup> Published with permission of the Chief Medical Director, Department of Medicine and Surgery, Veterans Administration, who assumes no responsibility for the opinions expressed or conclusions drawn by the authors.

of a registered nurse and physician. Each group was given a 5-minute explanatory talk on allergy and an explanation of the questions which were to be asked of them. Visual aid charts were used to simplify the presentation. The allergic history was then taken by a registered nurse. History of asthma, hay fever, allergic rhinitis, urticaria, contact dermatitis, migraine, and family frequencies was sought. Migraine was noted for interest and completeness, but results are not included in this report. Gastrointestinal allergy was noted only as urticaria. Vague epigastric symptoms following ingestion of various foods were not included. The histories obtained from the personnel are believed to be reasonably accurate.

The physical examinations were performed by a physician (R.M.M.) who had had special indoctrination by a qualified allergist. The conjunctivæ, nasal mucosa, and the nasopharyngeal mucosæ were examined visually. In addition, the groups were examined for evidence of dermatitis, emphysema, or asthmatic type of rales. Chest X-ray plates were made and examined for evidence of emphysema in any subject giving symptoms or signs of asthma.

2. *Patients.*—A preliminary survey of the diagnostic files of the patients of the hospital was made for those allergic conditions which had been previously diagnosed. Of a total of 1,875 patients, there were 9 diagnoses of allergic conditions reported. Thus a survey of the reports made by MacInnis and Leavitt, as well as our survey by diagnostic file, reveals an incidence of less than 1%, utilizing this method.

Subsequently, patients were individually surveyed by both history and physical examination in the same manner as the personnel. The histories obtained from patients were obviously far less authentic than those of the personnel by reason of the fact that the patients were psychotic. Only those taken from lucid patients were considered valid or reliable. As with the personnel control group, chest X-rays were made on all patients with a positive history or physical signs of asthma.

## RESULTS

1. *Control Group (Personnel).*—The survey of personnel was done between August 18, 1947 and September 4, 1947. The personnel were surveyed first inasmuch as it was anticipated that at this time the ragweed pollen count would be less intense than later so that, if a differential between patients and personnel were to be noted, the patients, being considered nonreactives, would be surveyed during the period of highest pollen counts. An examination of Table 1 indicates that this premise was valid, for, in general, the patients were surveyed during the period of higher counts.

Previous population surveys for allergic phenomena have reported percentages of positive allergic histories occurring in the population at large. The most generally accepted figure is that of Vaughn(3) as a result of a survey made in 1934. He reported a 10% incidence of major allergies in the general population. He characterized a major allergy as asthma, hay fever, or chronic recurring eczema. He noted further that approximately 50% of the population had minor allergies consisting of an occasional contact dermatitis or gastrointestinal allergic phenomenon. Service(4), in 1938, reported an over-all occurrence of positive allergic history in 20% of the general population. This included principally the major allergies.

The results of our survey of allergic history in the personnel control group are given in Table 2. Chronic and recurrent asthma, hay fever, allergic rhinitis, and hives were considered major allergies. The incidence in this group was 21%. This is closely comparable to Service's results of 20%. A breakdown indicates a positive history of asthma in 2.0%; hay fever in 8.85%; allergic rhinitis in 8.2%; and hives in 11.7%. Table 2 also compares our figures with those of Vaughn and Service.

Physical examination in the control group revealed an over-all percentage of positive allergic physical findings (Table 3) of 13%. Since our survey was performed during the ragweed season, 83 of the 99 individuals showing positive physical findings exhibited a pale blue, boggy, so-called allergic mu-

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cosa(5). This was differentiated from the swollen, glistening red, infected mucosa of virus and other infections. Thus, 11% of the control group had physical signs of pollen allergy as manifested by an allergic mucosa. In addition, a further 2.4% had nasal polypi; 0.4% had hives; 0.5% had contact dermatitis; and 0.9% had clinical

males, females, colored, and white, as shown by Table 4.

A review of the literature revealed no previous survey to indicate evidence of differences between incidence of allergic phenomena in Negro and white individuals. In the present survey, a total of 209 Negro employees were examined. Major allergic

TABLE 2  
ALLERGIC HISTORY (CONTROLS)

| Personnel allergic history<br>Total 757 personnel | Major allergies |           |                   |           | Total positives | Others             |          |
|---|-----------------|-----------|-------------------|-----------|-----------------|--------------------|----------|
|   | Asthma          | Hay fever | Allergic rhinitis | Urticaria |                 | Contact dermatitis | Migraine |
| No. positive history.....                         | 15              | 67        | 62                | 89        | 159*            | 237                | 6        |
| % positive history .....                          | 2.0             | 8.85      | 8.2               | 11.7      | 21.0            | 31.3               | 0.8      |
| % Vaughn—1934 .....                               | 3.3             | 5.3       | 2.9               | 4.9       | 10.0            | ...                | 3.1      |
| % Service—1938 .....                              | 3.0             | 10.0      | ...               | 2.6       | 20.0            | ...                | 2.7      |
| % Brey, Seigle, Crip.....                         | ..              | ...       | ...               | ...       | 10.0            | ...                | ..       |

\* A number of subjects had multiple allergies.

TABLE 3  
ALLERGIC BY EXAMINATION (CONTROL GROUP)

| Personnel allergic by examination<br>N = 757 | Major allergies       |        |                |           |        | Total positives | Others<br>Contact dermatitis |
|--|-----------------------|--------|----------------|-----------|--------|-----------------|------------------------------|
|  | Allergic nasal mucosa | Polyps | Conjunctivitis | Urticaria | Asthma |                 |                              |
| No. positive ....                            | 83                    | 18     | 6              | 3         | 7      | 99*             | 4                            |
| % positive .....                             | 11.0                  | 2.4    | 0.8            | 0.4       | 0.9    | 13.1            | 0.5                          |

\* A number of subjects had multiple allergies.

TABLE 4  
SUMMARY FOR CONTROL GROUP

| Results of histories and physical examinations of 757 personnel | Male personnel | Female personnel | Negro | White | White male | White female | Negro male | Negro female |
|---|----------------|------------------|-------|-------|------------|--------------|------------|--------------|
| No. of subjects.....  | 566            | 191              | 209   | 548   | 384        | 164          | 182        | 27           |
| No. with symptoms of allergy .....                              | 91             | 67               | 37    | 122   | 65         | 56           | 26         | 11           |
| % with symptoms of allergy..                                    | 16.0           | 35.4             | 17.7  | 21.0  | 16.9       | 34.1         | 14.2       | 41.0         |
| No. with signs of allergy.....                                  | 73             | 26               | 25    | 74    | 50         | 24           | 23         | 2            |
| % with signs of allergy.....                                    | 12.9           | 13.6             | 11.9  | 13.5  | 13.0       | 14.6         | 12.6       | 7.4          |

evidence of asthma. Of the 15 subjects with histories of asthma, 7 had asthmatic rales and large chest cages. None of these, however, showed typical evidence of emphysema. The discrepancy between 21% of the control group with symptoms and 13% with positive signs is accounted for by the fact that many of the subjects had positive histories of recurring hives but no physical signs at time of examination. Positive physical findings occurred to an equal extent in

histories occurred in 17.7% of this group as against 21% of white employees.

Vaughn made a survey of the difference between sexes and found an incidence of 19% in males and 25% in females. Our differentiation between male and female employees, including the Negro group, gives an incidence of 16% for males and 35.4% for females (Table 4).

2. *Test Group (Patients).*—As noted before, histories from patients were not con-

sidered valid and were not recorded unless the patient was quite lucid and/or the symptoms were substantiated by positive physical examination. Table 5 shows results of histories on 1,875 patients. Of this group, 108 or 5.7% had positive histories of allergy;

ther 0.48% had nasal polypi; 0.64% conjunctivitis; 0.10% had hives; and 0.43% asthmatic chests. Of the 8 patients with physical signs of asthma, 7 had X-ray evidence of emphysema and one had chronic bronchiectasis.

TABLE 5  
ALLERGIC HISTORY (TEST GROUP)

| Patients allergic history<br>N = 1,875 | Major allergies |           |                   |           | Total positives | Others             |                          |
|--|-----------------|-----------|-------------------|-----------|-----------------|--------------------|--------------------------|
|  | Asthma          | Hay fever | Allergic rhinitis | Urticaria |                 | Contact dermatitis | Total Negro patients 139 |
| No. positive history.....              | 20              | 43        | 43                | 28        | 108             | 0                  | 4                        |
| % positive history.....                | 1.06            | 2.3       | 2.3               | 1.5       | 5.7             | ..                 | 2.9                      |

TABLE 6  
ALLERGIC BY EXAMINATION (TEST GROUP)

| Patients allergic by examination<br>N = 1,875 | Allergic nasal mucosa | Major allergies |                |           |        | Total positives | Others             |                          |
|---|-----------------------|-----------------|----------------|-----------|--------|-----------------|--------------------|--------------------------|
|   |                       | Polyps          | Conjunctivitis | Urticaria | Asthma |                 | Contact dermatitis | Total Negro patients 139 |
| No. positive ....                             | 53                    | 9               | 12             | 2         | 8      | 56              | 0                  | 1                        |
| % positive .....                              | 2.8                   | 0.48            | 0.64           | 0.10      | 0.43   | 2.9             | 0                  | 0.7                      |

TABLE 7  
SUMMARY FOR TEST GROUP (PATIENTS)

| Results of histories and physical examinations of 1,875 patients | Male patients * | White | Negro |
|--|-----------------|-------|-------|
| No. of subjects.....   | 1,875           | 1,736 | 139   |
| No. with symptoms of allergy .....                               | 108             | 104   | 4     |
| % with symptoms of allergy .....                                 | 5.7             | 6.0   | 2.9   |
| No. with signs of allergy .....                                  | 56              | 55    | 1     |
| % with signs of allergy .....                                    | 2.9             | 3.2   | 0.7   |

\* No female patients.

A breakdown as to mental diagnoses is shown in Table 8. Of the 1,341 schizophrenic patients examined, 5.7% had positive histories of allergy; and 2.9% showed signs of allergy. Of the 69 manic-depressive patients, 2.9% had symptoms by history and 1.4% had signs of allergy. Of 31 epileptics, 4 patients, or 13%, had both symptoms and signs of allergy. The group of 434 patients with organic psychoses, over 50% of whom were paretics, included cerebral vascular accidents, senile psychoses, 1 mental defective, various

TABLE 8  
INCIDENCE BY DISEASE

|  | Schizophrenia | Manic-depressive | Epileptics | Organic psychoses |
|--|---------------|------------------|------------|-------------------|
| Total No. ....                         | 1,341         | 69               | 31         | 434               |
| No. positive history.....              | 77            | 2                | 4          | 21                |
| % positive history.....                | 5.7           | 2.9              | 13.0       | 4.8               |
| No. positive physical examination..... | 38            | 1                | 4          | 13                |
| % positive physical examination.....   | 2.9           | 1.4              | 13.0       | 3.0               |

1.06% gave symptoms of asthma; 2.3% of hay fever; 2.3% of allergic rhinitis; and 1.5% of hives.

Of the total group of patients examined, 56 or 2.9% had physical signs of allergy; 53 of the 56 positives were demonstrated by an allergic nasal mucosa (Table 6). A fur-

ther 0.48% had nasal polypi; 0.64% conjunctivitis; 0.10% had hives; and 0.43% asthmatic chests. Of the 8 patients with physical signs of asthma, 7 had X-ray evidence of emphysema and one had chronic bronchiectasis.

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### FURTHER COMPARISON OF TEST AND CONTROL GROUP

The control group of 757 subjects consisted of 191 women and 566 men. Because the test group consisted entirely of male patients, comparative ages were made only with males of the control group of 566 men. The breakdown between male patients and male personnel is as follows:

| Age           | Percent of group                  |                               |
|---------------|-----------------------------------|-------------------------------|
|               | Control group<br>(Male personnel) | Test group<br>(Male patients) |
| 10-19 .....   | 2.1                               | 0.4                           |
| 20-29 .....   | 48.5                              | 22.0                          |
| 30-39 .....   | 20.0                              | 15.0                          |
| 40-49 .....   | 12.0                              | 16.0                          |
| 50-59 .....   | 14.0                              | 38.0                          |
| Over 60 ..... | 3.2                               | 0.8                           |

It can be seen that, while the control group was predominantly young men, the test group was more evenly distributed throughout various ages, with a higher percentage in the 50- to 60-year age group.

### COMMENT

Molholm(6) reports that schizophrenic patients are more difficult to sensitize to injections of foreign protein than normal controls. Bauchemin(7) reports that schizophrenic and manic-depressive patients are rarely sensitive to the usual allergens on skin test but are quite allergic to endocrine substances. Our results indicate that these same groups of patients are less responsive to the summer and fall air-borne pollens than are normal controls. Epileptics, on the other hand, were noted by Bauchemin to be quite sensitive to the usual allergies. Winkleman and Moore(8) and Clark(9) have suggested that dreamy states, states of confusion, and hallucinatory episodes may be due to focal angioneurotic edema of the brain. Our results show an incidence of sensitivity among our epileptic patients comparable to that of our normal controls, though the series is too small to be conclusive. Of interest, Gillespie(10), MacInnis(1), Karnosh(11), all report noting disappearance of allergic phenomena during psychotic episodes with recurrence when the psychosis is in remission.

### SUMMARY

A control group of 757 personnel and a test group of 1,875 neuropsychiatric patients were surveyed for symptoms and signs of allergy. In order to validate the material, the survey was made when an allergen (ragweed pollen) was a common environmental circumstance for both groups in the same geographical location. The survey, by history, among the control group revealed an incidence of major allergic symptoms of 21% and an incidence by physical signs of 13%. This group represented a cross section of the population for the area in which the study was made.

Among the test group of patients, the majority of whom were psychotic, the incidence of symptoms by history was 5.7%, and the incidence of positive physical signs, 2.9%. The incidence of physical signs among schizophrenic patients was 2.9% and among manic-depressive psychotics, 1.4%. Among epileptics, it was 13% and among organic psychoses, 3.0%. The survey is considered valid since it was made under controlled conditions, the findings were objective, and the survey is open to repetition.

### CONCLUSIONS

1. The incidence of major allergy among psychotic patients is remarkably less than among individuals not suffering from such disorders.
2. Compared with an incidence of positive physical findings of allergic response to ragweed pollen of 13% in the general population, the incidence among schizophrenic patients was revealed to be 2.9% and among manic-depressive patients, 1.4%. Among organic psychoses, the incidence was 3.0% and among epileptics, 13%.

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ther 0.48% had nasal polypi; 0.64% conjunctivitis; 0.10% had hives; and 0.43% asthmatic chests. Of the 8 patients with physical signs of asthma, 7 had X-ray evidence of emphysema and one had chronic bronchiectasis.

TABLE 5  
ALLERGIC HISTORY (TEST GROUP)

| Patients allergic history<br>N = 1,875 | Major allergies |           |                   |           | Total positives | Others             |                          |
|--|-----------------|-----------|-------------------|-----------|-----------------|--------------------|--------------------------|
|  | Asthma          | Hay fever | Allergic rhinitis | Urticaria |                 | Contact dermatitis | Total Negro patients 139 |
| No. positive history.....              | 20              | 43        | 43                | 28        | 108             | 0                  | 4                        |
| % positive history.....                | 1.06            | 2.3       | 2.3               | 1.5       | 5.7             | ..                 | 2.9                      |

TABLE 6  
ALLERGIC BY EXAMINATION (TEST GROUP)

| Patients allergic by examination<br>N = 1,875 | Allergic nasal mucosa | Major allergies |                |           |        | Total positives | Others             |                          |
|---|-----------------------|-----------------|----------------|-----------|--------|-----------------|--------------------|--------------------------|
|   |                       | Polyyps         | Conjunctivitis | Urticaria | Asthma |                 | Contact dermatitis | Total Negro patients 139 |
| No. positive ....                             | 53                    | 9               | 12             | 2         | 8      | 56              | 0                  | 1                        |
| % positive .....                              | 2.8                   | 0.48            | 0.64           | 0.10      | 0.43   | 2.9             | 0                  | 0.7                      |

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| Results of histories and physical examinations of 1,875 patients | Male patients * | White | Negro |
|--|-----------------|-------|-------|
| No. of subjects.....   | 1,875           | 1,736 | 139   |
| No. with symptoms of allergy .....                               | 108             | 104   | 4     |
| % with symptoms of allergy .....                                 | 5.7             | 6.0   | 2.9   |
| No. with signs of allergy .....                                  | 56              | 55    | 1     |
| % with signs of allergy .....                                    | 2.9             | 3.2   | 0.7   |

\* No female patients.

A breakdown as to mental diagnoses is shown in Table 8. Of the 1,341 schizophrenic patients examined, 5.7% had positive histories of allergy; and 2.9% showed signs of allergy. Of the 69 manic-depressive patients, 2.9% had symptoms by history and 1.4% had signs of allergy. Of 31 epileptics, 4 patients, or 13%, had both symptoms and signs of allergy. The group of 434 patients with organic psychoses, over 50% of whom were paretics, included cerebral vascular accidents, senile psychoses, 1 mental defective, various

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### SUMMARY

A control group of 757 personnel and a test group of 1,875 neuropsychiatric patients were surveyed for symptoms and signs of allergy. In order to validate the material, the survey was made when an allergen (ragweed pollen) was a common environmental circumstance for both groups in the same geographical location. The survey, by history, among the control group revealed an incidence of major allergic symptoms of 21% and an incidence by physical signs of 13%. This group represented a cross section of the population for the area in which the study was made.

Among the test group of patients, the majority of whom were psychotic, the incidence of symptoms by history was 5.7%, and the incidence of positive physical signs, 2.9%. The incidence of physical signs among schizophrenic patients was 2.9% and among manic-depressive psychotics, 1.4%. Among epileptics, it was 13% and among organic psychoses, 3.0%. The survey is considered valid since it was made under controlled conditions, the findings were objective, and the survey is open to repetition.

### CONCLUSIONS

1. The incidence of major allergy among psychotic patients is remarkably less than among individuals not suffering from such disorders.
2. Compared with an incidence of positive physical findings of allergic response to ragweed pollen of 13% in the general population, the incidence among schizophrenic patients was revealed to be 2.9% and among manic-depressive patients, 1.4%. Among organic psychoses, the incidence was 3.0% and among epileptics, 13%.

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## CLINICAL NOTES

### THE USE OF ORAL BARBITURATES IN PSYCHOTHERAPY

LEOPOLD BELLAK, M. A., M. D., NEW YORK, N. Y.

To overcome resistance and enable the patient to free-associate is one of the outstanding problems of psychotherapy in general, and of brief psychotherapy in particular. We deal with material repressed to avoid anxiety, and it stands to reason that a decrease of anxiety would lead to a decreased need for repression.

This is a brief report on the author's use of small doses of barbiturates taken orally by the patient prior to the psychotherapeutic session to overcome his resistance and inability to communicate significant material. This method has been used for a year and a half in about 30 patients with results as described below.

The procedure is much simpler than the administration of intravenous sodium amytal, which is particularly difficult in private practice. In addition, frequent intravenous punctures are not possible in some patients and not advisable in any; and hypnosis as an attempt to short-cut resistance is not usable with a great number of patients and neither liked nor easily mastered in its more involved techniques by every psychiatrist. However, the occasional use of either method in conjunction with the routine oral administration of barbiturates for psychotherapeutic purposes is not at all contraindicated.

*Administration.* The preparation usually employed was sodium pentobarbital, Abbott, (nembutal). In a few cases the dosage was  $\frac{3}{4}$  grain initially, to ascertain that the patient would not manifest any exaggerated responses. The customary dosage was then  $1\frac{1}{2}$  grains taken one-half hour before the beginning of the session. It turned out in every case to be harmless except in one patient with a conversion hysteria who reported, the first time, brief symptoms of visual disturbance which she herself likened to those experienced in a mild alcoholic intoxication. After some reassurance, she continued the medication without any difficulty. The effect of the drug was usually described

as a mild degree of relaxation. Contrary to expectations practically none of the patients experienced a degree of sleepiness that interfered with carrying on their routine business. (The same dosage, however, had a distinctly soporific effect—in the same patients—when taken at bedtime with the general mental set of readiness to fall asleep). The patients are not informed of the nature of the drug. An occasional patient felt a slight drowsiness or unsteadiness for a few moments after getting up from the couch. They were advised to get a cup of coffee in the nearest drug store if the drowsiness persisted. A few patients received 3 or 4 grains of caffeine by mouth at the end of the first few sessions, but soon refused it as unnecessary. As pointed out later, some depressed patients received nembutal and desoxyn (Abbott—desoxyephedrine hydrochloride), a stimulant; the two drugs together had an excellent effect on their productivity. There is not the slightest reason to suspect that any of the patients have become habituated or addicted.

*Indications and Case Material.* Oral barbiturates were used whenever patients had *difficulty in free-associating*. With some patients they were used only *initially* to overcome inhibitions; with others, *episodically* when particular resistance hindered working through of specific problems(1); with some patients barbiturates were used almost continuously.

In 2 patients with *agoraphobia* nembutal was used very successfully in the beginning of the treatment. The trip to the office—unmanageable at first—did not constitute a problem when the patients took  $1\frac{1}{2}$  grains of nembutal one-half hour before leaving home. Throughout the sessions the sedation greatly facilitated production of material as compared to hours when the patient did not take the drug.

*Character neuroses* were another indication for the use of the sedative. One patient

with obsessive-compulsive features was literally unable to speak for stretches as long as 10 minutes when the drug was not used. She dreaded the sessions greatly. With the use of the drug free association proceeded well. When the drug was experimentally withheld on several occasions, the previous difficulties recurred, in the early treatment stage.

Another patient with a character neurosis, mostly hysterical features, almost playfully tried to antagonize by superficial, irrelevant associations. With the help of barbiturates she permitted herself to show real affect and entered the therapeutic situation. In a number of very bright patients who could discuss any of their problems glibly without the least emotional participation, the nembutal brought about a decisive change for the better; some actually wept, showed bitterness, or aggression, and generally associated more usefully.

Still another specific use was found in *depressed patients* whose psychomotor retardation interfered with useful communication. In these cases, desoxyn, mg. 2.5, was often combined with the nembutal. Such depressed patients who were not actively suicidal were carried in the office practice on a regimen of  $\frac{3}{4}$  grain, or  $1\frac{1}{2}$  grains of nembutal combined with  $2\frac{1}{2}$  mg. of desoxyn upon arising and at 1 p. m. Four or five of these patients would have had to be institutionalized or would not have been able to carry on their business, or would have needed electric shock treatments without this regimen which permitted carrying them through successful psychotherapy. The desoxyn should hardly ever be taken later than 1 p. m. since it might

otherwise interfere with falling asleep at night. The nembutal desoxyn mixture worked also very satisfactorily in several depressed and inhibited *schizophrenics*, and in 2 reactive depressions. One of them described the mixture as "sunshine pills." The desoxyn seems to counteract the slowing up possible in depressions without counteracting the sedative effect of nembutal and vice versa. (A similar effect has also been observed when both caffeine and sodium amytal were administered in catatonics.)

The therapeutic manipulation of the anticipatory anxiety in ejaculation *præcox* and female frigidity by nembutal half an hour prior to intercourse is being experimented with.

Nembutal has thus far been tried only in brief psychotherapy and in conjunction with the use of the Thematic Apperception Test (2). In psychoanalysis proper the analysis of resistance is a valuable therapeutic procedure. However, a certain optimum is often exceeded and the use of the procedure in such cases is contemplated. This will throw light on the oral gratification which the giving of oral medication may cause (a point raised by my colleagues, Drs. A. Rosner, M. Stein, and G. Werner). I do not believe that this gratification accounts for the described response, since desirable results were not reached when only  $\frac{3}{4}$  grain of nembutal was used, which was too small a dose for practically all the subjects.

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# PROCEEDINGS OF SOCIETIES

## THE AMERICAN PSYCHIATRIC ASSOCIATION

### PROCEEDINGS OF THE ONE HUNDRED AND FOURTH ANNUAL MEETING<sup>1</sup>

HOTEL STATLER, WASHINGTON, D. C.

MAY 17-20, 1948

#### MONDAY MORNING SESSION MAY 17, 1948

The 104th annual meeting of The American Psychiatric Association convened at 9:30 a.m. in the Presidential Ballroom of the Hotel Statler, Washington, D. C., the President, Dr. Winfred Overholser, of Washington, D. C., presiding.

CHAIRMAN OVERHOLSER: The 104th annual meeting of The American Psychiatric Association will please be in order.

It seems highly appropriate to open our meeting with a greeting from the President of the United States. Dr. Menninger has received a communication addressed to the Association which he has been good enough to permit me to read to you.

#### "THE WHITE HOUSE WASHINGTON

"May 15, 1948.

"DEAR DR. MENNINGER:

"The well being of the American people is one of our greatest concerns and I am aware of the very special needs in the area of mental health. It gives me, therefore, great pleasure to send hearty greetings to the members of The American Psychiatric Association and of the American Psychoanalytic Association in the hope that their annual conventions will be fruitful of wise counsels in the solution of the important problems which they will consider.

"Never have we had a more pressing need for experts in human engineering. The greatest pre-

<sup>1</sup> Because of the exceptional length of the report of annual Proceedings and increased printer's costs publication has been delayed. The Executive Committee has now authorized reporting the Proceedings of the 1948 annual meeting in the accompanying condensed form.

The remaining material including reports of standing committees, which the chairmen have kindly abstracted for this purpose, will appear in the June issue of the JOURNAL.

The full record of all Proceedings and the full committee reports are on file at the head office in New York and available for reference.—Ed.

requisite for peace, which is uppermost in the minds and hearts of all of us, must be sanity—sanity in its broadest sense, which permits clear thinking on the part of all citizens. We must continue to look to the experts in the field of psychiatry and the other mental sciences for guidance in the evaluation of our mental health resources.

"To become a mentally healthful nation we must make a supreme effort to enable all people to achieve satisfaction, security, and peace of mind. I hope that your meetings will be successful in bringing us closer to these goals.

"Very sincerely yours,  
(signed) "HARRY S. TRUMAN"

We deeply appreciate this greeting from the President, and the Secretary will see that suitable acknowledgement is made.

It is now my pleasure to present to you the President-Elect, Dr. William Menninger.

Dr. Menninger was presented.

Dr. Overholser then delivered the Presidential Address. After he had concluded, the audience arose and applauded.

DR. MENNINGER: Dr. Overholser, tradition gives the President-Elect the opportunity to express to the President our appreciation. I first want to express to Dr. Overholser our appreciation and recognition of his many contributions to psychiatry. I am sure I voice the sentiment of our membership in expressing to him our appreciation for his leadership and his service to this Association through the years and as our President this present year.

And, last, I should like to express to him again in the name of the membership our appreciation for this very challenging and thoughtful and stimulating presentation. I should like to assure him that we shall do our best to carry it out.

CHAIRMAN OVERHOLSER: Thank you, Dr. Menninger and fellow members of the Association.

The following message has been received from Dr. Samuel Ramirez Moreno of Mexico City: "Please express to the President and the members of The American Psychiatric Association my best wishes for the success of this annual meeting."

The next item is a report from Mr. Austin Davies on the Psychiatric Foundation. I have already alluded to this in my remarks. Mr. Davies.

Mr. Davies read the report of the Psychiatric Foundation, which will be found on a later page of the Proceedings with the special reports.

Chairman Overholser: We will now hear from the Chairman of the Committee on Arrangements, Dr. Dexter Bullard.

Dr. Bullard reported arrangements for tea at the White House for the ladies and for the annual banquet Wednesday night at which the George Washington Glee Club will furnish music and the speaker will be Mr. Sumner T. Pyke, of the Atomic Energy Commission, the dinner to be followed by dancing.

CHAIRMAN OVERHOLSER: We would like to hear from the Chairman of the Committee on Program, Dr. Frank J. Curran.

Dr. Curran read the report of the Committee on Program, which will be found on a later page of the Proceedings with the special reports.

CHAIRMAN OVERHOLSER: We are grateful to the peripatetic Dr. Curran for the large amount of work he and his committee have done on this program. It is one of the most difficult assignments, and one perhaps least appreciated by the membership; but we think, on the whole, we have a pretty good program for you this year.

I would like to call on our Secretary, Dr. Leo Bartemeier, for a report.

Dr. Bartemeier read a summary of the membership figures, which will be found on a later page of the Proceedings with the special reports.

DR. BARTEMEIER (continuing): The following message has been sent to Dr. Lloyd Yepsen, the President of the Association on Mental Deficiency, holding its centennial meeting in Boston this morning:

"The members of The American Psychiatric Association send their cordial greetings and best wishes for a successful meeting to the members of the Association on Mental Deficiency, and hope that in a future annual meeting our two associations may meet at the same time, in the same city."

(Signed) "WINFRED OVERHOLSER, President,  
American Psychiatric Association.

The following resolution, prepared by Dr. Burlingame and his Committee on Public Education, has been approved by the Council, and is presented to you for adoption before being sent forward.

Dr. Bartemeier read the following resolution which was unanimously adopted:

"At this critical time, delay of the United States in regard to participation in World Health Organization is sterilizing long, earnest, and costly efforts on the part of The American Psychiatric Association and its associates in the fields of nursing, psychology, social work, and education.

"Men of good will in twenty-seven nations have cooperated toward a world mental health effort in August, 1948 in full confidence that the World Health Organization, as an integral part of their plan, would be an imminent reality. That the United States of America, of all nations, with its finest of traditions in world health leadership, would delay, was not foreseen, and the entire promise of success is correspondingly compromised.

"With great interest, and great faith, the American public is looking to the psychiatric profession for the answers to the problem of mental illness, which is international in scope. The greatest of all public health problems, mental illness, yearly takes hundreds of millions of American dollars from the States of the Union. The Federal government is adding its tens of millions of dollars to attack this problem of the ages. It is a fact that the number of hospital beds devoted to children's diseases, surgical cases, tuberculosis, cancer, and other diseases, when all added together, fall far short of the number devoted to mental diseases. More are added to this number annually, and the dreary picture goes on and on. The best brains in the psychiatric world, indeed, in the entire scientific world, are needed, to solve this problem.

"The World Health Organization is an essential part of our plans actively under way to solve this problem. Time is the essence to protect this investment in effort, money, and international good will among psychiatrists."

CHAIRMAN OVERHOLSER: I would like to call on our Treasurer, Dr. Howard W. Potter, for a brief report.

DR. HOWARD W. POTTER: Since the detailed report of the finances of the Association will be published, I wish now to comment on just a few of the points about our finances. As of March 31, 1948, our net resources amounted to approximately \$85,500. This sum represents cash in various checking and savings bank accounts, and United States Government and Canadian Government bonds.

The total income for this past fiscal year, ending March 31, 1948, amounted to \$137,270, and the total expenses amounted to \$94, 546, which left us a surplus for the year of nearly \$43,000.

Just a word concerning this present year. If the Medical Director is to carry out his plans, if the various committees are to be more active, that will entail considerable additional expense. We anticipate that the expenditures during this coming year will probably be increased between \$50,000 and \$60,000. This means that we have to increase our income by some \$15,000 to \$20,000. The income can be increased by new membership, upgrading of present members, and by putting the *Journal* on its feet financially through increasing its circulation.

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Dr. Bartemeier read a summary of the membership figures, which will be found on a later page of the Proceedings with the special reports.

DR. BARTEMEIER (continuing): The following message has been sent to Dr. Lloyd Yepsen, the President of the Association on Mental Deficiency, holding its centennial meeting in Boston this morning:



CHAIRMAN OVERHOLSER: Night before last an old friend, and a good one of many of us, had dinner in London; yesterday morning he had breakfast in Labrador; and last evening he was here for dinner with The American Psychiatric Association—a very good example of the way that distances are being annihilated. We are happy that Brigadier John R. Rees was able to get here in time to speak to us this morning and tell us something of the plans which are going forward for the International Congress on Mental Health. It is a joy to be able to present to you once again General John R. Rees of London.

Brigadier Rees addressed the Association and reported plans under way for the International Congress on Mental Health to be held in London from August 11 to 21, 1948. On behalf of his London colleagues Brigadier Rees expressed the hope that as many of the members of the Association as possible would attend the Congress.

CHAIRMAN OVERHOLSER: Thank you very much for your warm invitation, and we hope that a large number of our members will be able to accept.

Continuing on the matter of the International Congress, I should like to call on Dr. Frank Fremont-Smith, one of the American Vice-Presidents of the International Committee for Mental Hygiene, who has been very active in making arrangements both on this side of the water and the other.

Dr. Frank Fremont-Smith discussed the financial needs of the Congress.

CHAIRMAN OVERHOLSER: I hope the membership realizes that this is practically the only country in the whole world that does not have currency limitations with Great Britain. It will be extremely difficult for some of the people to travel to London from other countries, and that is one of the objects for which some of this money will be used.

While we are on the subject of Anglo-American relations, I should like to call on Dr. R. G. MacInnes, of Oxford, England, who brings the greetings of the Royal Medico-Psychological Association of Great Britain, our sister and slightly older society. Dr. MacInnes!

Dr. MacInnes on behalf of the President of the Royal Medico-Psychological Association of Great Britain conveyed warmest fraternal greetings of that body to The American Psychiatric Association in their annual convention, together with best wishes for a successful meeting. He extended also a hearty invitation to attend the annual meeting of the Royal Medico-Psychological Association in London in July prior to the Congress.

CHAIRMAN OVERHOLSER: Thank you very much, Dr. MacInnes. I know that you will convey to your Association our warmest and friendliest greetings, and the hope that we may meet many of your colleagues this summer.

The Secretary has a few announcements to make.

DR. BARTEMEIER: I have been asked to tell you that there will be a meeting of all hospital superintendents or their representatives, of private, state, and federal mental hospitals, at 8 o'clock this evening in the Congressional Room, on this floor.

The members of the Hofheimer Prize Committee will have lunch in the Town Room following this morning's meeting.

The Naval Reserve Luncheon today at noon is to take place in the Pan American Room.

We have also been requested to make known to you the following communication: "The Naval Air Reserve Training Command, with headquarters at Naval Air Station, Glenview, Illinois, has 18 nationally located Naval Air Stations and 4 Naval Air Reserve Training Units at which Naval Reserve Medical Officers may serve on active duty with full pay and allowances, and with the privilege of returning to civilian life at any time upon request. Additional details may be obtained from Chief of Naval Air Reserve Training, Naval Air Station, Glenview, Illinois."

CHAIRMAN OVERHOLSER: I should like to announce the appointment of the Committee on Resolutions. I have asked Dr. William B. Terhune, of New Canaan, Connecticut, to serve as Chairman, with Dr. Sydney Maughs, of St. Louis, and Dr. George E. Reed, of Montreal, Canada. That committee will report on Thursday morning.

Yesterday at the Council meeting we arranged to send greetings and regrets to two of our Past Presidents who are unable to be with us, Dr. Adolf Meyer, and Dr. Ross M. Chapman, both of Baltimore. I know that you all join in our regret that they are physically unable to attend.

We now come to the memorial to deceased members. I will ask those present if they will please rise while the Secretary reads the list.

The Secretary read the list of deceased members as follows:

Hugh Hampton Young, Baltimore, Md., died Aug. 23, 1945.

Bruno Solby, Washington, D. C., died Sept. 8, 1945.

Patricia Steen, Hempstead, N. Y., died Sept. 15, 1946.

Holmer E. Perrine, Ft. Worth, Tex., died Nov. 22, 1946.

Milton Goldberg, Los Angeles, Calif., died, Dec. 10, 1946.

John Favill, Chicago, Ill., died Dec. 21, 1946.

Eugene L. Youngue, Lakin, W. Va., died Dec. 24, 1946.

Maurice A. R. Hennessy, Cleveland, O., died Dec. 31, 1946.

C. S. Roy, Mastai, Que., died Dec. 31, 1946.

John H. Trevaskis, New York, N. Y., died Dec. 31, 1946.

Pierre Janet, Paris, France, died Feb. 24, 1947.  
Lois E. Taylor, Belchertown, Mass., died Mar. 21, 1947.

Frank Dwyer, Bellingham, Wash., died Mar. 30, 1947.

David E. Bixby, Cleveland, O., died Apr. 4, 1947.  
Edward G. Rowland, Trenton, N. J., died Apr. 9, 1947.

Frederick C. Robbins, Crystal Beach, Fla., died Apr. 16, 1947.

Robert F. Sheehan, Scarsdale, N. Y., died Apr. 16, 1947.

Rose Pringle, New York, N. Y., died May 8, 1947.

Albert G. Odell, Clifton Springs, N. Y., died May 19, 1947.

John T. MacCurdy, Cambridge, England, died June 1, 1947.

Edward L. Hanes, Monroe Co., N. Y., died June 15, 1947.

Claude R. Laird, Hastings, Nebr., died July 5, 1947.

Nicholas W. Pinto, Ferndale, Mich., died July 5, 1947.

Clifford V. Tisdale, Woodstock, Ont., died July 16, 1947.

Lloyd J. Nelson, Queens Village, N. Y., died July 22, 1947.

James A. Cummins, Hamilton, Canada, died Aug. 14, 1947.

V. H. Podstata, Berkeley, Calif., died Aug. 15, 1947.

Charles H. Dolloff, Concord, N. Y., died Aug. 18, 1947.

Clement B. Masson, New York, N. Y., died Sept. 5, 1947.

James S. Plant, Newark, N. J., died Sept. 7, 1947.

Charles A. Brake, Norman, Okla., died Oct. 7, 1947.

Henry M. Chandler, Orangeburg, N. Y., died Oct. 19, 1947.

Richard H. Hutchings, Utica, N. Y., died Oct. 28, 1947.

Clarence O. Cheney, White Plains, N. Y., died Nov. 4, 1947.

Albert L. Crane, Evansville, Ind., died Nov. 17, 1947.

James V. May, Belmont, Mass., died Dec. 24, 1947.

**CHAIRMAN OVERHOLSER:** It is our practice to prepare special memorial notices on the death of Past Presidents. This year we have been particularly unfortunate in losing no less than three. Dr. Ross Chapman had prepared a memorial on Dr. James V. May, but is unable to be here. He has sent his memorial, which I will ask the Secretary to read.

**DR. BARTEMEIER:** Dr. James V. May, President of The American Psychiatric Association in 1932-33, died in Boston, Mass., December 24, 1947. He was born in Lawrence, Kansas, July 6, 1873, and after graduating from the University of Kansas with the degree of A.B. in 1894 he attended the University of Pennsylvania Medical School, receiving the de-

gree of M.D. in 1897. He served as interne in "Old Blockley," and as assistant physician on the staff of Brigham Hall, Canandaigua, New York. After a short period of service there he was appointed Acting Assistant Surgeon in the Army, and spent 1½ years in that capacity in the Philippines during the insurrection.

On his return to civil life in 1942 he entered the state hospital service of New York, joining the staff at the Binghamton State Hospital after a few months at Central Islip. His interests there were largely clinical and pathological. In 1911, after advancing to the grade of first assistant physician, he was appointed Superintendent of the Matteawan State Hospital, but shortly thereafter was elevated to the position of Chairman of the State Hospital Commission. In this position he proved himself an able and progressive administrator, and did much to amalgamate the state hospitals into an outstanding system.

After 5 years at Albany Dr. May accepted the superintendency of the Grafton State Hospital in Massachusetts. His work here was interrupted by the outbreak of World War I. He had been a reserve officer since 1911, and was assigned to duty as major at Camp Devens, Mass. The superintendency of the Boston State Hospital (then including the Boston Psychopathic Hospital) became vacant in the fall of 1917, and the Trustees secured Dr. May's release from the Army to fill this position.

Dr. May's career at the Boston State Hospital was a brilliant one. Not only was he a superb administrator, but he maintained an active interest in the clinical aspects of the work, writing one book (*Mental Diseases: A Public Health Problem*, 1922) and numerous long articles on various aspects of psychiatry, such as a translation of Wilmann's "Review of Schizophrenia," "The Dementia Praecox—Schizophrenia Problem," and "Psychoses of the Period of Involution."

Upon the death of Dr. George M. Kline, then Commissioner of Mental Diseases, in January 1933, Dr. May was asked by Governor Ely to serve as successor—probably the only man to have been Commissioner of Mental Diseases in two states! In June 1934, however, he returned at his own request to the Boston State Hospital. There he remained as Superintendent until he retired in December 1936. He continued to maintain a keen interest in psychiatric developments. Dr. May underwent a serious operation in the fall of 1947, and after showing an apparent improvement, suddenly relapsed and died. He is survived by his widow, the former Ada L. Arms, and two children.

Dr. May's interest in The American Psychiatric Association persisted throughout his professional life. A strong believer in the value of organization, he served as Councillor, as member of the Committee on Nomenclature and Statistics, and as President (1932-33). He was active in bringing about the change in name (1921) of the Association, but the accomplishment upon which he prided himself the most was his part in establishing the American Board of Psychiatry and Neurology. A

large part devoted to standard by the The con Board is vision.

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large part of his Presidential Address in 1933 was devoted to the need of establishing for psychiatry standards "fully equivalent to those already erected by the surgeons, internists . . . and pediatricists." The conspicuously successful work of the American Board is a monument to Dr. May's foresight and vision.

Dr. May was interested also in "grass roots" medical organization, and was one of the founders of the Massachusetts Psychiatric Society, the first district organization recognized by The American Psychiatric Association. He was President of that Society in 1927-28 and of the New England Society of Psychiatry in 1933-34. He was also a corresponding member of the Royal Medico-Psychological Association of Great Britain and foreign associate member of the Société Médico-Psychologique of France. He was a diplomate in psychiatry of the American Board.

A student of psychiatry, a historian, a wise, progressive, and firm administrator of hospitals and of the Association, a warm and loyal friend, James V. May played a long and important rôle in the evolution of hospital psychiatry. Those workers in the field who were so fortunate as to come under his influence will long cherish his memory and value his contributions to psychiatric progress.

CHAIRMAN OVERHOLSER: Dr. Samuel W. Hamilton will present the memorial to Dr. Clarence O. Cheney.

DR. HAMILTON: Clarence O. Cheney was born in Poughkeepsie, New York, June 10, 1887. He died in White Plains, New York, on Nov. 4, 1947, of a cerebral hemorrhage. He had been secretary and treasurer of this Association 1928-1933, President-Elect 1934-1935, and President 1935-1936, following which he served the usual three years on Council. He served also on important committees and was one of our original representatives on the American Board of Psychiatry and Neurology. He worked forcefully for this Association, held high its ideals, and contributed much to its success and prestige.

From Columbia College he was graduated in 1908 and from the College of Physicians and Surgeons in 1911. Joining the staff of the Manhattan State Hospital, for several years he was its pathologist. Then he became assistant director of the State Psychiatric Institute which in those days had wards and laboratories in the plant of that hospital. In 1922 he went to Utica as assistant superintendent. The position had been created in what was a relatively small hospital because nine miles away a new institution was growing in Marcy. Dr. Cheney, under the direction of the late Richard H. Hutchings, spent most of his time developing what later became the Marcy State Hospital. Here his administrative capacity had scope while at the same time in the parent institution he continued his special studies.

In 1926 he was appointed superintendent of the Hudson River State Hospital at Poughkeepsie. Five years later, in 1931, he was called to the directorate of the State Psychiatric Institute, which

had moved from Ward's Island to the Medical Center. Seldom in this country is a hospital head invited to forsake the life for which he has fitted himself and take charge of a program of teaching and research, but Dr. Cheney's intellectual and temperamental equipment for the post were well recognized and for five years he directed the broad program of that institution.

The Society of the New York Hospital draws many of its ablest physicians from the New York State service. When in 1936 the position of medical director of the Westchester Division needed to be filled, Dr. Cheney was the natural choice. There he expanded the program of training for physicians and various types of staff. That hospital like others experienced stresses during the war period and its burdens were heavy, but Dr. Cheney in spite of warnings about his physical health remained at his post until the end of June 1946, when he retired.

While stationed on Ward's Island he held a teaching post in Cornell Medical School and during the war also taught in New York University. At Utica he was a member of the medical faculty of Syracuse University. While Director of the Institute he was professor of psychiatry in Columbia and on removal to White Plains he became professor of clinical psychiatry in Cornell. He was a member of psychiatric organizations where he lived and elsewhere (including England) and frequently was called on to be a committeeman or officer. He served on various committees of the National Committee for Mental Hygiene. He was a Fellow of the American Medical Association and the New York Academy of Medicine. He was for years an associate editor of the *American Journal of Psychiatry* and of the *Psychiatric Quarterly*. He held membership in the honorary societies Sigma Xi and Alpha Omega Alpha. In 1944 he was awarded the Columbia University medal for professional distinction and public service. On various occasions he did service for his state and the nation. His social life included a national fraternity, a service club, and the University Club of White Plains.

Dr. Cheney was a forthright man who could be expected to reason directly to the center of any controversial matter. His opinion was always listened to with respect, and could convert a minority into a majority. He was enthusiastic when his opponents could stoutly maintain an opposite opinion, but for empty theorizing he had little sympathy. His administration of institutional business was meticulous, but he stood ready to modify standard procedures in order to help people in difficulties. To those who brought him their troubles he gave immediate attention. He was a warm friend, and thoroughly trusted. His students remembered for years his case presentations.

The titles of his papers and the substance of his official reports range all the way from brain changes in dementia praecox to the psychiatry of mythology. His revision of outlines for psychiatric examinations is used in mental hospitals throughout the land.



Dr. Cheney well knew that by inheritance and constitution he was liable to arterial accident. When such accidents came he showed natural concern, but he was not one to shirk duty because of temporary incapacity. Always when given a choice of activity, it was natural for him to do rather than be passive. Until late he participated in vigorous sports. Happily he was permitted to maintain much activity up to a few hours before the final accident.

In 1915 Dr. Cheney married Josephine Scott, who survives him with a son, Robert Scott Cheney. This Association shares their sorrow, and as well their happy memories of the vigorous and devoted character to whom they were so closely attached.

CHAIRMAN OVERHOLSER: Dr. Russell E. Blaisdell will present the memorial to Dr. Richard H. Hutchings.

DR. BLAISDELL: In the death of Dr. Richard H. Hutchings the world lost a wise physician, an excellent administrator, and a high-minded citizen. His career was one of great achievements, yet through it all there shines the light of a kindly, modest gentleman who drew the respect, admiration, and loyalty of those who were privileged to work with him or to know him intimately. Many of the physicians holding high places in the profession today have paid tribute to his greatness and for the inspiration gained from him. His death, which occurred in Utica, New York, on October 28, 1947, followed a brief illness while he was still practising psychiatry and was serving as editor-in-chief of the *Psychiatric Quarterly*, the official organ of the New York State Department of Mental Hygiene and a widely read psychiatric journal.

Dr. Hutchings was born in Clinton, Georgia, on August 28, 1869. His father, who died when Dr. Hutchings was five years old, had emigrated from Virginia following the American Revolution. His mother's ancestors came from Georgia and neighboring Southern states. Dr. Hutchings' charm and many personal characteristics traceable to his Southern origin were unchanged by long residence in the North. He obtained his early education at a private school in Macon, Georgia, and at the Georgia Military School. After one year at Georgia University he entered Bellevue Medical College, from which he received his medical degree in 1891. Following an internship of one year at the Almshouse on Blackwell Island, he served at the New York City Asylum on Ward's Island a brief period until he was appointed to the staff of the St. Lawrence State Hospital at Ogdensburg, New York, on May 24, 1892, where he served under Dr. Peter M. Wise, a recognized administrator of great ability. Promotions followed in the service of that institution and in September 1903 he was appointed superintendent at the very early age of 34.

Dr. Hutchings' administration was characterized by efficiency and progress. He advocated voluntary admissions for suitable cases and the number admitted in his hospital greatly exceeded the number of such admissions in other institutions. His was one of the first New York state hospitals to es-

tablish a mental hygiene clinic in the community, which has long since been an established practise among mental institutions. In 1908 he organized habit training and recreation for regressed and idle patients and demonstrated its effectiveness in raising the general level of behavior in these patients.

For many years Dr. Hutchings was chairman of the Committee on Statistics of the Department, which revised the statistical tables and made recommendations for the preparation of the annual reports of the institutions.

For several years typhoid fever was prevalent at the Ogdensburg institution and during his investigations of an epidemic in 1903 Dr. Hutchings discovered that typhoid bacilli remained viable in ice for long periods and to this fact the spread of the disease in the hospital was attributed. Discontinuance of the use of impure ice from St. Lawrence River was followed by success in the control of typhoid in the hospital. This is thought to be the first recorded instance of the part ice may play in causing typhoid epidemics, and its recognition has added to the epidemiology of the disease.

Having volunteered his services early in World War I and been commissioned as captain of the Reserve Corps Dr. Hutchings was, in August 1917, ordered into active service, promoted to the rank of major and assigned to Columbia, S. C., to examine the 81st Division. Later he was given a special assignment in the Surgeon-General's Office and in July 1918 was appointed Chief of Neuropsychiatry of General Hospital No. 31 at Plattsburg Barracks, N. Y. He continued in the service until February 1919.

While still in military service he was chosen by the Department to become, in April 1919, the head of Utica State Hospital, where an extensive building program was projected including the construction of the Marcy Division of the Utica institution which became a separate hospital by legislative action in 1931.

Dr. Hutchings was keenly interested in nursing. He recognized the importance of a school of nursing in raising the standards of nursing care in a mental hospital. At St. Lawrence State Hospital he developed one of the largest and most efficient schools in the New York State hospital system. Soon after going to Utica he led in the organization of the Central Training School of Nurses where state hospital students received their preliminary training with pupil nurses of the general hospitals of Utica. He became president of this training school. He gave lectures to student nurses and strongly supported psychiatric training in state hospitals of affiliates from general hospital schools. Under his administration Utica State Hospital also became a fine training center for occupational therapists. In 1908 Dr. Hutchings became a lecturer on psychiatry at the Medical School of Syracuse University and eventually was made Professor of Clinical Psychiatry Emeritus of Syracuse University.

Dr. Hutchings had an open mind and was a seeker of truth. Unshackled by tradition and dogmatism he was one of the first in America to

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espouse the theories of Freud and to apply them in teaching and clinical practise at a time when Freudianism was treated with contempt by most of the leading psychiatrists of the country. What was then looked on as heresy and took courage to express has long since been generally recognized as fundamental in the understanding of psychopathology and is therefore taught in every medical school. He was a member of the American Psychoanalytic Society and was chairman of the section on psychoanalysis during 1936-1937. He was a Fellow of The American Psychiatric Association and was elected to its presidency in 1938.

Dr. Hutchings made numerous contributions to psychiatric literature. One of the more notable ones was the *Psychiatric Word Book*—a lexicon of terms employed in psychiatry and psychoanalysis, designed for students of medicine and nursing and psychiatric social workers. It has gone through six editions; a seventh edition is in press. He was appointed a member of the Medical Editorial Board of the *State Hospital Quarterly* in 1919 and in 1933 became the editor-in-chief of the *Psychiatric Quarterly*.

Dr. Hutchings not only was a progressive leader in the medical field but also took an active part in community affairs. He served as president of the Associated Charities of Utica, was president of the Utica Torch Club, and for many years was a member of the Utica Rotary Club.

Dr. Hutchings is survived by his wife, Mrs. Lillie Compton Hutchings, a son, Dr. Charles W. Hutchings, assistant director at Manhattan State Hospital, Ward's Island, New York City; a daughter, Mrs. Raymond Alberts, who entered psychiatric social service following graduation from college; and several grandchildren. There was another son, Richard H. Hutchings, Jr., who was director of clinical psychiatry at Harlem Valley State Hospital at Wingdale, New York, at the time of his death December 14, 1938.

Dr. Hutchings has gone but he still lives in the hearts and minds of innumerable persons who have felt the touch of his kind and beneficent spirit.

CHAIRMAN OVERHOLSER: One of our very distinguished honorary members died during the year, a man of international reputation and a great historical figure, Pierre Janet. I have asked Dr. Raymond de Saussure, of New York City, to present a memorial to Dr. Pierre Janet.

DR. DE SAUSSURE: Pierre Janet was born in 1859, three years after the birth of Sigmund Freud. He died in February, 1947, at the age of eighty-eight. He retained up to the end of his life an active and quick mind.

After having been professor of philosophy in Rennes, he graduated as doctor of medicine, worked a long time in Charcot's clinic and, in 1896, became professor of psychology in the Collège de France.

In 1910 he founded the *Journal de Psychologie Normale et Pathologique*. He belonged to many French and foreign scientific societies. Let us recall that he was a honorary member of The American Psychiatric Association and the American Neurological Association. He visited the United

States several times and delivered lectures at different American universities.

Janet grew up at the time of the scientific successes of Claude Bernard. His ambition was to make psychology a science as accurate as physiology is. First he trained in philosophy like his two brothers Jules and Paul Janet, and worked under the influence of Hyppolite Taine and Theodule Ribot, trying to sever psychology from its philosophical cradle.

He understood that psychology could improve only through the study of detailed observations. He was an indefatigable worker and he first spent hours to record minute observations made on his patients. The slightest fact aroused many questions in his curious mind, but he was very cautious and always preferred an accurate description to an attempt at explanation.

It was often said that German psychiatry answers the question, "Why is a man insane?"; British psychiatry answers the question, "How do you cure an insane person?"; and French psychiatry answers the question, "What are the various forms of insanity?" Pierre Janet was deeply rooted in French tradition. He was primarily interested in a clear distinction of facts.

In his book *Psychological Automatism*, written in 1889, three years before Freud's first psychoanalytic paper, he was interested in the various hysterical symptoms and in hypnotic regression. Patients with anesthesia and even hysterical blindness were brought back under hypnosis, by suggestion, to the age of seven or six. In this state of regression their symptoms vanished because they were reëxperiencing a period prior to their pathogenic trauma.

Janet organized these experiments to prove that hysterical disorders were purely functional. He did not understand at that time their therapeutic implications. It was the privilege of Freud to discover them.

Janet never did accept the psychodynamic point of view; he continued his purely descriptive studies and in 1892 published two comprehensive volumes on the mind of hysterics, a subject to which he came back in two other publications in 1911 and 1917, respectively. In 1898 he wrote two volumes on *Neuroses et Idées Fixes* and in 1903 two others on obsessions. In 1926 he devoted two volumes to anxiety and ecstasy. This considerable descriptive work will certainly have a historical value and will show to the psychiatrist of later centuries how the patient of the end of the 19th century reacted. These are social documents of the highest value.

Pierre Janet also devoted three volumes to mental healing. Later he studied general problems of psychology, like memory, growth of intelligence, love and hatred, and the individual in his social reactions.

Pierre Janet leaves us a very great amount of work which is difficult to appreciate fully today. We are at present under the influence of psychodynamic formulations and Janet's teachings sound somewhat obsolete, but the future may well bring

new syntheses in which his work will find its adequate appreciation.

CHAIRMAN OVERHOLSER: From the list that was read to you, there was one name that I think calls for mention, although he was not an honorary member or a Past President. I do not wish to let this opportunity go by, though, without saying just a word about A. A. Brill, a man who did much, perhaps more than any other, to introduce into this country the writings of Sigmund Freud, and who was considered throughout his active life one of the most honored champions of those teachings; a man who was an active worker in the Association, a close personal friend of many of us, a great historic character as well as an able clinician. Certainly we should and shall long remember Dr. A. A. Brill.

This concludes, ladies and gentlemen, the proceedings of the forenoon.

Following the announcement of afternoon meetings, the meeting adjourned at 12 o'clock.

## TUESDAY MORNING SESSION

MAY 18, 1948

The General Session convened at 9:30 a. m. in the Presidential Ballroom of the Hotel Statler, Dr. Winfred Overholser presiding.

CHAIRMAN OVERHOLSER: Ladies and gentlemen, will the meeting please come to order? I will ask the Secretary to make some announcements.

DR. BARTEMEIER: I wish you to know that the following message is being sent to Dr. N. Emmons Paine, 110 Plimpton Street, Walpole, Massachusetts:

"Greetings to our oldest member of The American Psychiatric Association.

(Signed) Dr. Winfred Overholser."

Dr. Paine has been a member of this Association since 1887.

There will be a meeting of all who are associated with or interested in the neurology and psychiatry programs of the Veterans Administration at the District of Columbia Medical Society Auditorium, Tuesday, May 18, at 5:00 p.m. The Administrator of Veterans Affairs and the Chief Medical Director will address the meeting.

CHAIRMAN OVERHOLSER: Thank you, Mr. Secretary. Dr. N. Emmons Paine is 93 years old. He regretted deeply that he could not come. He is our oldest member in years, and I think in membership—61 years a member of this Association.

We have one member who, although not a member for quite so long, is pressing Dr. Paine in years. I should like to ask Dr. C. F. Menninger, of Topeka, Kansas, to stand up and be recognized.

Dr. Menninger arose and was applauded.

CHAIRMAN OVERHOLSER: The first business of the morning is the report of the Nominating Com-

mittee. I will ask Dr. Douglas A. Thom to give that report.

DR. THOM: The Nominating Committee proceeded in accordance with the resolution passed at the Section dealing with the nomination of officers, and approved by the Council, at the annual meeting in New York, May 1947. This resolution read that:

"The Nominating Committee solicit the opinions of the entire voting membership as to nominations and this should be done in December preceding the annual meeting."

Approximately 4,300 questionnaires were sent out to all members of The American Psychiatric Association. Eight hundred twenty-two (822) or slightly less than 20% were returned, of which 764 came from Fellows and Members, 58 from Associate and Life Members. Thirty per cent (30%) of the Fellows and 15% of the Members returned the questionnaires.

Your Committee met in Chicago January 31, 1948. Two members, Dr. William N. Keller and Dr. Raymond S. Crispell, were unable to attend, the former on account of illness, and the latter because his plane was grounded due to adverse flying conditions. Dr. Crispell wired the chairman making known his choice of candidates for nomination. The Committee reviewed the tabulation of suggestions, as compiled from the questionnaires, for nominations of officers and councillors of the Association, giving priority in their deliberations and final conclusions to the expression of opinion received from the voting members. Consideration, however, was given to the geographical location of Councillors in order that various sections of the country might be represented on the Council so far as vacancies permitted. After thoughtful deliberations the following names were selected and are presented to the Association for their consideration as officers and councillors for the ensuing year:

President-Elect, Charles C. Burlingame.

Secretary, Leo H. Bartemeier.

Treasurer, Howard Potter.

Councillor for one year: Abram Bennett.

Councillor for three years: Henry Brosin.

Councillor for three years: D. Ewen Cameron.

Councillor for three years: Jack R. Ewalt.

Telegrams notifying the absent members of the Committee of the results of the Nominating Committee's deliberations at this meeting were sent by the chairman, and approval received.

The Secretary of the Association, Dr. Leo H. Bartemeier, and Dr. Clarence B. Farrar, Editor of the American Journal of Psychiatry, were immediately informed of the Nominating Committee's report, in order that it might be published in the American Journal of Psychiatry at least one month before the Annual Meeting, according to Article 6, Section 1 of the Constitution and By-Laws.

CHAIRMAN OVERHOLSER: You have heard the report of the Nominating Committee. Under the Constitution, nominations may be made from the floor.

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DR. DEXTER BULLARD: A number of the Fellows and Members have been concerned by the action of the Nominating Committee in presenting the name of only one person as a candidate for the highest honor that this Association can bestow. It is believed by the members that there is more than one Fellow with qualifications for the presidency and that a choice should have been offered us.

Accordingly, I have been asked to place in nomination for the presidency the name of one who since 1927 has quietly but actively been identified with the aims of the Association, and who has made contributions of significance to psychiatry, especially in the field of preventive work.

Since being called to head the National Committee for Mental Hygiene as Director, he has shown grasp and comprehension of its field. He has shown organizational capacity of a high order, and has been signally successful in the selection and the recommendation of men and women for work in the mental hygiene clinics throughout the country.

Also, I personally believe that it is more fitting that The American Psychiatric Association have for its leader one who has long been associated with the preventive aspects of our work than that the Association be represented by one whose current views frequently lean toward psychosurgery and lobotomy.

Ladies and gentlemen, it is my privilege to nominate for the presidency George S. Stevenson.

CHAIRMAN OVERHOLSER: You have heard the nomination of Dr. George S. Stevenson.

DR. F. H. ALLEN: It is a pleasure to second the nomination of Dr. George S. Stevenson for the highest office the Association can offer to its members. He has long been associated with the field of psychiatry that is concerned with prevention. His quiet but very effective efforts have been constantly directed toward a broader understanding of psychiatric principles. He has played a very important role in securing important legislation throughout the country, particularly the Mental Health Act. The honor of being nominated for this office is a very important one, and I take great pleasure in seconding the nomination of George S. Stevenson for President.

DR. KARL M. BOWMAN: I think that the democratic process is such that there should be free opportunity and that we should welcome one, two, or more nominations. I do object, and I say so most emphatically, to attacks on any candidate in the manner in which the original person nominated Dr. Stevenson. I think that is a highly improper thing to have been done in this Association. I do not think it should affect those who support Dr. Stevenson in the least, and I do not in the least consider Dr. Stevenson responsible, but I do think that it is not proper to get up and nominate one candidate and make derogatory remarks against another.

I think Dr. Stevenson is a very suitable candidate and, if elected, would make an excellent President, and I have no question in that matter. I would like to say that, in my opinion, if Dr. Burlingame

were elected, he would also make an excellent President, and I would like to point out that the Nominating Committee made their nominations, paying due attention to the expressed opinion after polling the Association as requested.

DR. GEORGE H. PRESTON: I think that there is a time in the history of most organizations when it is necessary for a strong Nominating Committee to guide the future of an organization and so hold it together. I think that there are other times, particularly in times of change, and particularly when there is, as expressed here today, a very marked difference of opinion in thinking about psychiatry, when it is necessary that an organization follow our traditional democratic procedure of having more than a single candidate presented in open meeting, so that the membership may have an opportunity to express their own opinion. That, to me, is more important than either candidate—the chance of an organization to say what the individual members think, and then follow our tradition of backing up gladly and wholeheartedly the will of the majority.

Because I am convinced of that, I wish to second the nomination of Dr. Stevenson, whom I have known since I knew the word "psychiatry," who I believe knows as many members of this organization as almost any other person, and who has demonstrated certain abilities that are relatively unique, one of which is the ability to get along and to accomplish things with this strange organization in this city, the Federal Government, and its methods of doing business. That is a rare quality which I think would be highly valuable to the President of The American Psychiatric Association.

CHAIRMAN OVERHOLSER: Does anyone else wish to be recognized for any purpose having to do with nominations?

DR. HARRY STACK SULLIVAN: I am sorry to impose on your good nature but I am so touched by the sole consideration Dr. Preston mentioned that I wish to add my little voice. I believe psychiatry has vast problems, problems in research, problems in theory, and problems in education, and I think the only hope we have of making any very conspicuous progress on those in the near future depends on the support of the Federal Government.

I must say that, being anything but enthusiastic for public education organizations, I watched Dr. Stevenson's career for many years with increasing appreciation of this very inconspicuous, possibly somewhat remote person. He knows what he is doing. He is without conspicuous prejudices as to what psychiatry needs, and he can, more than any one I can think of offhand, be a good spokesman for the research and educational needs of psychiatry to the Federal Government.

DR. EDWARD A. STRECKER: If there are no more nominations, I move the nominations be closed.

The motion was regularly seconded and carried.

CHAIRMAN OVERHOLSER: Are there any nominations for other officers?



DR. STRECKER: I would like to nominate for the Council a loyal, effective, constructive worker in the affairs of the Association for many years, Dr. Thomas Ratliff.

CHAIRMAN OVERHOLSER: Are there any further nominations or seconds?

DR. KARL M. BOWMAN: May we ask whether that is for one of the three-year positions or the one-year position?

CHAIRMAN OVERHOLSER: There are four nominees. It is an unusual situation. A year ago a member of the Council, Dr. William C. Menninger, was elected President-Elect. There is no provision in the Constitution and By-Laws for filling vacancies as they occur in the Council. Consequently, there has been a vacancy for the past year. Dr. Bennett has been nominated to fill that unexpired term of Dr. Menninger.

DR. STRECKER: I nominate Dr. Ratliff for the three-year term.

CHAIRMAN OVERHOLSER: Dr. Strecker wishes to clarify the nomination of Dr. Thomas A. Ratliff, of Cincinnati, by saying that is for the three-year term.

DR. KARL A. MENNINGER: I would like to second that nomination.

CHAIRMAN OVERHOLSER: Dr. Karl Menninger seconds the nomination. Are there any further nominations?

DR. WILLIAM MALAMUD: I would like to nominate for the office of Councillor for three years Dr. Francis J. Braceland, a man who is well known to us and highly respected for the work he has done as Chief of the Neuropsychiatry Division of the United States Navy, who has done great work on the Board of Psychiatry and Neurology, who is a great teacher and clinician.

CHAIRMAN OVERHOLSER: Dr. Malamud nominates Dr. Francis J. Braceland of Rochester, Minnesota, Secretary of the American Board of Psychiatry and Neurology. That nomination likewise is for the three-year term.

DR. THOMAS A. C. RENNIE: I would like to second that nomination of Dr. Braceland.

DR. MARION E. KENWORTHY: I would like to nominate Dr. Frederick Allen, of Philadelphia, as a Councillor for three years.

CHAIRMAN OVERHOLSER: Dr. Kenworthy nominates Dr. Frederick Allen, of Philadelphia, for the three-year term. We now have three nominations in addition to those proposed by the Nominating Committee, namely, Dr. Ratliff, Dr. Braceland, and Dr. Allen. Are there any other nominations?

DR. WILFRED BLOOMBERG: Some of you may remember the part I had in nominations or change of nominations for Councillors two years ago. I would like to show you how I feel about it by putting in nomination for Councillor for three years the name of Dr. Harry C. Solomon, of Boston.

CHAIRMAN OVERHOLSER: Dr. Bloomberg nominates Dr. Harry C. Solomon, of Boston. There are now four nominated for the three-year term in addition to the three nominated by the Nominating Committee. If there are no further nomi-

inations, a motion is in order to close the nominations.

It was moved by Dr. Tarumianz, seconded by Dr. Felix, and the motion carried that all nominations be closed.

CHAIRMAN OVERHOLSER: Now for the matter of voting, we have set up in the next room, near the registration desk, a polling booth. By vote of council, the polls will be open until 4:00 p.m. As you will bear in mind, associate members are not entitled to vote. The voting is limited to Fellows and Members. Associate members will bear in mind, please, that their votes will be challenged if they attempt to vote.

I have asked Dr. Harry J. Worthing, of New York, to act as chief teller and the following to assist Dr. Worthing: Dr. Robert Morse, of the District of Columbia; Dr. Charles Tidd, of California; Dr. Richard Kepner, of Hawaii; Dr. L. R. Vezina, of Quebec; Dr. Ralph Rossen, of Minnesota; Dr. Joseph L. Knapp, of West Virginia; Dr. H. M. Galbraith, of Oklahoma; Dr. R. Burke Suitt, of North Carolina; Dr. Harry F. Hoffman, of Allentown, Pennsylvania; Dr. D. L. Steinberg, of Illinois; Dr. Francis H. Stieber, of Maine; Dr. J. Berkeley Gordon, of New Jersey.

That will not impose undue hardship on any of the tellers. Two will be on duty at all times. The names will be doubly checked. The ballots will be deposited in a closed, locked, and sealed box, which will not be opened until after 4 o'clock when the voting has ceased. The votes will then be tabulated and I will ask Dr. Worthing if he will have at least two of the other tellers sign the report with him and make a report tomorrow morning on the results of the balloting.

It would be appreciated if the assistant tellers whose names I have read would meet with Dr. Worthing immediately at the polling booth in order that arrangements may be made about hours and suitable relief.

I hope that all those eligible to vote will vote. It will probably be the only time in the history of the Association that has happened, but I hope it will happen this time. A good deal has been said about democracy, and let's make sure it is 100% democracy instead of 33%. A list of nominees will be posted in the neighborhood of the polling booth.

It is now a great pleasure to present to you the newly appointed Medical Director, Dr. Daniel Blain.

Dr. Blain read the report of the Medical Director.<sup>2</sup>

CHAIRMAN OVERHOLSER: We now turn to the reorganization portion of the meeting. Under the auspices of the Committee on Reorganization, we have been fortunate in securing the presence of one of the fabulous figures of American medicine,

<sup>2</sup> Incorporated in the President's Page of the April 1949 issue of the JOURNAL, page 786.

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a man who knows a lot about a lot of things, and one of the things he knows a great deal about is medical organization, its history and evolution in various types of setup throughout the country. He is an extremely busy man, who flits hither and yon working all the time when he isn't reading detective stories. I am very happy to present to you an old friend and good friend of the Association, Dr. Morris Fishbein, the Editor of the *Journal of the American Medical Association*.

Dr. Fishbein addressed the membership on the subject of medical organization as exemplified particularly by the American Medical Association.

CHAIRMAN OVERHOLSER: Thank you very much, Dr. Fishbein. Dr. Fishbein is able to remain so that you may ask him questions after the Chairman of the Committee on Reorganization has given his report. I should like to ask the members of the Committee on Reorganization and the members of the Executive Committee if they will join us on the platform.

Before we proceed may I announce that the Council will meet at 3 o'clock tomorrow. May I say for the benefit of the various nominees to the Council that the results of the election will be announced tomorrow morning, and those elected will take office and those three or four members who go off the Council will cease to function in that capacity.

I now present Dr. Karl Menninger, Chairman of the Committee on Reorganization.

Dr. Menninger first called upon Dr. Thomas A. Ratliff, who outlined briefly the history of the Committee; next, upon Dr. LeRoy Maeder, who discussed the formulation of the proposed new constitution and by-laws.

Dr. Menninger then discussed the proposed reorganization of the Association as represented graphically on a large chart on the wall behind the speaker's desk.

Dr. Menninger next called upon Dr. Arthur P. Noyes, who described the proposed division of North America into 28 districts, each to be represented by a constituent district society.

Dr. Menninger then called upon Dr. D. Ewen Cameron, who discussed criticisms that had been expressed concerning the proposed reorganization, as well as points in its favor. He suggested three points for the members to take under consideration: first, that membership under the proposed reorganization ought not to cost more (he estimated that the average annual cost to a Fellow would

be approximately \$50); second, that the new constitution, if accepted, should not become effective until two-thirds of the district societies are duly constituted; third, that the proposed plan is not the only way of developing an organization nor, as presented, necessarily in its final form.

Dr. Menninger then called upon Dr. Maeder, who summed up the more important features of the proposed constitution, the manner in which the Association and the constituent societies would operate, and the questions of future developments and of increased dues.

DR. MENNINGER: There is one detail of the constitution in which many of you are interested, and I am going to call on Dr. Thomas Rennie to explain our point of view in regard to this detail.

Dr. Rennie discussed the proposed representation in the Association of affiliated services—psychiatric social workers, psychologists, psychiatric nurses and others, with the recommendation that members of these groups be brought in as "affiliates of The American Psychiatric Association."

DR. MENNINGER: This completes the report of our Committee. It will be discussed when it comes up for your action next year. We will now spend the rest of our time answering questions from the floor.

DR. ARTHUR C. RUGGLES: May I ask Dr. Rennie, would the affiliate group have membership dues and votes and be on committees?

DR. RENNIE: It is anticipated that they will pay dues—and the additional source of revenue is important for this organization—but they will not vote.

DR. MURRAY: I would like to ask, why has the Air Force been left out?

DR. MENNINGER: Suggest that when you write us. The Air Force was not created when we did this.

DR. MURRAY: I thought they were fighting all during the last war.

DR. MENNINGER: They were, but they were part of the Army.

QUESTION: I see dangers in this. You will perhaps permit a small minority, which is well organized, from one district society or a small group of district societies, to run it, instead of permitting—

DR. MENNINGER: It is precisely what we have to avoid. No small minority can get control unless you constantly elect that small minority to do so. If you want to elect those people from your district, remember that there are 27 other districts, and incidentally, some delegates at large. It will be hard for anybody to organize all the districts, we think, in such political fashion.

DR. PAUL LEMKAU: By what means is it suggested that the district organizations be formed?

DR. MENNINGER: Of course, a good many of these district societies already exist. For example, we suggested that the state of Massachusetts might be a district. There is now a Massachusetts Psychiatric Society. All they would have to do would be to vote to become a constituent society instead of an affiliate society.

Some of the districts are not set up, or at least no organization now exists, but any enterprising Fellows or Members in those districts could call a meeting and as soon as 50% or more are represented, and they so vote, they become eligible for recognition as a district society.

DR. SAMUEL W. HAMILTON: Mr. Chairman, two questions, the first of the committee, the second of Dr. Fishbein. In view of the fact that the A.M.A. has one delegate for 1,000 members, has the Reorganization Committee considered the possibility of a House of Delegates for us that would not be so much greater in proportion to membership than that of the A.M.A.?

The second question of Dr. Fishbein: Do any of the academies to which we seem to be somewhat similar have affiliates who are not physicians?

DR. MENNINGER: I will ask Dr. Fishbein to answer the second question first, if he will.

DR. FISHBEIN: None of the academies have affiliates who are not physicians, but I take it that your evolution is toward the style of the American Heart Society more than it is toward the academies. The American Heart Society does have a variety of affiliates, including members of the lay public who are especially interested.

Dr. Fishbein also referred to his recent survey of practitioners of clinical psychology, vocational and marriage counseling, psychiatric counseling, etc. He pointed out that there had been a tremendous increase in psychiatric and psychological quackery; and that there were no state laws to control such charlatanism because no standards for the qualification of technical consultants have been established. It is the function of both the American Psychological Association and The American Psychiatric Association to set up such standards.

Dr. Menninger asked Dr. Fishbein to answer also Dr. Hamilton's other question.

Dr. Fishbein expressed opposition to the nominating committee method and recommended nominations from the floor. He illustrated his remarks by reference to incidents in recent A.M.A. history. He criticized a House of Delegates which tended to become too large and suggested that a group of 100 to 200 should operate efficiently and would represent a variety of viewpoints.

Dr. Menninger pointed out that the proposed reorganization plan is not modeled after the A.M.A. but rather after that of the American Heart Association.

Dr. Oskar Diethelm inquired as to the function of the annual meeting and also whether features of the so-called town meeting could be combined with the proposed plan "in order to overcome concern that this reorganization may become reactionary instead of truly progressive."

Dr. Menninger invited written suggestions as to how these features could be combined. He stated that the function of the annual meeting would be the same as at present. He suggested that one political function would probably be to elect the 18 members at large of the House of Delegates. He stated in reply to a question that, as outlined in the plan, delegates at large are nominated by the House of Delegates. However, this was one of the points left open for the membership to consider.

QUESTION: Will this organization with its district societies tend to decentralize the interests so that most of the attendance and papers will be given in the district societies, with the result that the attendance at the annual meetings will fall off?

DR. MENNINGER: That has not occurred in some other organizations. It does not occur in the American Heart Society or in the A.M.A. Meetings of the county and state societies do not keep the best papers from being read at the meetings of the A.M.A. It was our impression that it would not, from other experience.

QUESTION: What would be the advantage of having the House of Delegates elect the general officers rather than the general assembly, with nominations by the House of Delegates?

DR. MENNINGER: That may be a good way to do it; send it in.

QUESTION: What is the advantage of doing it this way?

DR. MENNINGER: I think the general idea is that as this organization reaches 10,000, you never will be able to get 10,000 people present to vote, whereas they do have a vote indirectly through their delegate, if the House of Delegates elects. At the present time the people who elect the officers, are not all the members, but only those who attend the meeting. Strictly speaking, it is not democratic and the idea of the House of Delegates electing was directed to that end.

DR. FISHBEIN: When the A.M.A. was much smaller, the representatives on the Council on Medical Education, the Judicial Council, and the Council on Scientific Assembly or Forum were nominated to the House of Delegates by the President. The President nominated one man and it was

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not possible to have another man considered. That is exceedingly undemocratic, and it was used for a number of years by the President to pay off political debts.

Therefore, in the case of the official councils, the Board of Trustees nominates to the House of Delegates three men for each position. The House of Delegates then selects by vote the one that they wish to appoint to that particular position.

Bear in mind that the Board of Trustees canvasses the whole country to find three men who are interested, who represent a proper geographic distribution, who are willing to work, but the Board cannot appoint them; the House of Delegates makes the final decision. It is not only more democratic but also a more efficient procedure.

QUESTION: Is it possible by the use of preferential ballots by mail to have the membership at large elect its officers? Was that possibility considered as an alternative?

DR. MENNINGER: Yes, it was considered carefully. If you favor that method, send in the recommendation, and if there is enough objection to this system we can get it changed.

QUESTION: In making up the districts, was it in proportion to geographical distribution or in proportion to the number of psychiatrists in the area?

DR. MENNINGER: To the number of psychiatrists.

QUESTION: Would the affiliates be proportionate in relationship to the district society and would they have to have a relationship to the district society?

DR. MENNINGER: Yes, they do. They are elected.

QUESTION: Why is it suggested that the members of the House of Delegates should be elected for 2 years and the members of the Board of Trustees should be appointed for 3 years? Why are they not changed yearly?

DR. MENNINGER: We thought there would be some continuity by not having them all changed at once, and that plan would provide some overlapping. But if it is wrong, the terms can be changed.

QUESTION: Is it not possible, instead of having affiliate members of The American Psychiatric Association, to have an affiliate society, with the endorsement of the A.P.A., for the recognition of these individuals to whom we wish to give affiliate membership?

DR. MENNINGER: Yes, it is possible; but we are not making them affiliate members. It was carefully explained that the psychologists, social workers, and others will not be members of this Association; they will be affiliates.

DR. BARTEMEIER: I have been requested to inform you that the registration for the present meeting as of 6 o'clock last evening was as follows: members, 1,188; guests, 1,263; a total attendance of 2,451.

CHAIRMAN OVERHOLSER: The main session will begin in this room tomorrow morning at 9 o'clock. You all know about the various section meetings this afternoon.

The meeting adjourned at 12 o'clock.

### WEDNESDAY MORNING SESSION

MAY 19, 1948

The third General Session convened at 9:15 o'clock, Dr. Overholser presiding.

CHAIRMAN OVERHOLSER: Will the meeting please come to order.

Will Dr. Worthing please give the report of the results of yesterday's election.

DR. HARRY J. WORTHING: *Mr. President, Ladies and Gentlemen:* The total votes cast at yesterday's election, 773.

For President-Elect, Dr. Stevenson, 389; Dr. Burlingame, 342.

For Secretary, Dr. Bartemeier, 733.

For Treasurer, Dr. Potter, 727.

For Councillors for three years: Dr. Brosin, 549; Dr. Cameron, 499; Dr. Ewalt, 357; Dr. Braceland, 239; Dr. Allen, 202; Dr. Solomon, 151; Dr. Ratliff, 78.

For Councillor for one year, Dr. Bennett, 631.

For Auditor, Dr. McConnell, 701.

CHAIRMAN OVERHOLSER: You have heard the report of the tellers, and we appreciate, Dr. Worthing, your efforts and those of your associate tellers in this difficult task of counting ballots and supervising the election.

It would appear from the vote as recorded that you have elected the following:

President-Elect, Dr. George S. Stevenson.

Secretary, Dr. Leo Bartemeier.

Treasurer, Dr. Howard Potter.

For Councillors for three years, Dr. Henry Brosin, Dr. D. Ewen Cameron, and Dr. Jack Ewalt.

For Councillor for one year, Dr. Abram Bennett.

For Auditor for three years, Dr. Whitman McConnell.

It may interest you to know that up to 6:00 p.m. yesterday, 1,389 members were registered and 1,490 nonmembers, a total of 2,869.

The next item of business is the election of members. You have before you the list of the members proposed. The list has been prepared by the Committee on Membership after careful investigation, and has been approved by the Council. A total of 100 are proposed for associate membership, 311 for full membership, 3 reinstatements, 16 transfers from associate to member, 50 transfers from member to fellow, 5 corresponding members, 5 honorary members, and 10 transfers from fellow to life member.

This list need not be acted on as a whole. Anyone has a right to question any name on it, but it is perfectly proper, if anyone chooses to make a motion, to move that the list as submitted be accepted and that the persons named on it be elected to the corresponding grades of membership.

It was moved, seconded, and carried that the list be accepted as prepared, and the persons named on the list were declared elected to the corresponding grades.



CHAIRMAN OVERHOLSER: You will note that there are five honorary members. Three of these are well-known psychiatrists or neurologists: Karl Bonhoeffer of Berlin, Otto Kauders of Vienna, Gonzalo Lafora of Madrid. We have also two very good friends of psychiatry, one a physician and one a lay woman, whom we have chosen and are happy to honor. General Howard Snyder is not present this morning but he will be here this evening and I shall ask him to rise and be recognized.

It is a great personal pleasure to me, as a long-term associate, to ask Miss Mary Switzer to rise. For the benefit of those few who may not know about Miss Switzer, let me say that she is assistant to the Federal Security Administrator. The Federal Security Agency is that agency of the government which has to do primarily with health and welfare. She has shown herself for many years in that capacity to be a close friend of medicine in general, and of psychiatry in particular. We are very happy to have her on our list of honorary members.

There will be a meeting of the Council in the District Room at 3:00 p.m. today. Drs. Brosin, Cameron, Ewalt, and Bennett are specifically requested to attend, since they take office immediately.

The next item of business is the report of the Council. I will ask the Secretary to give that report.

DR. BARTEMEIER: The Council met Dec. 13 and 14, 1947 and approved recommendations of the Executive Committee: that the application of the Missouri Society for Neurology and Psychiatry to become an affiliate society be accepted; to contribute \$10 to sponsor the annual meeting of the National Council on Family Relations; to contribute \$25 to the National Conference on Family Life and to send 3 representatives to the Conference; to establish a Committee on Cooperation with Lay Groups (10 members); to increase the salary of Miss Martha Lavell, editorial assistant, by \$400; to continue the Psychiatric Personnel Placement Service, with the service not limited to members of the Association; that the Editor of the JOURNAL be authorized to lease an office at a rental ceiling of \$100 per month.

The Council recommends that the 1949 meeting of the Association be held in Montreal, Canada; the 1950 meeting in Dallas, Texas; and the 1951 meeting in Cincinnati, Ohio.

The Council recommends that the Association give every support to the International Congress on Mental Health to be held in London, England in August 1948. It was voted that the President, Dr. Overholser, and the President-Elect, Dr. W. C. Menninger, constitute the 2 vice-presidents to the Congress from The American Psychiatric Association. The nomination of 6 speakers at the Congress from the Association was referred to the Executive Committee.

The Council recommends that the Association participate in the International Congress on Psychiatry to be held in Paris, France in 1950 and voted to authorize a contribution to this Congress not exceeding \$200.

The recommendation of the Committee on Psychiatric Standards and Policies that the President appoint a Central Inspection Board, consisting of 10 Fellows, was approved.

The following joint resolution from the Committee on Psychiatric Standards and Policies and the Committee on Hospitals of the Group for the Advancement of Psychiatry was adopted:

"Be it resolved that The American Psychiatric Association, through its Council, endorse and support and, through its Committee on Psychiatric Standards and Policies, aid in the development of a plan in cooperation with other psychiatric groups, specifying at least the Group for the Advancement of Psychiatry, the National Committee for Mental Hygiene, and such other groups as may be deemed necessary.

"To formulate material to submit to the National Advertising Council for a campaign on the subject of mental health.

"Following the current trend it seems advisable to give top priority to the problems of the State Hospitals as the subject matter for such a campaign. In preparation of such a campaign the Council endorses the plan of a conference of approximately 150 psychiatrists, composed of Commissioners, Superintendents of Mental Hospitals, representing every section of the country as well as delegates from various national organizations interested in mental health."

The Committee on Reorganization reported that it has no nominee for the position of Director of Public Education. The Council voted that Dr. Daniel Blain be offered the position of Medical Director, established at the last meeting, and that the Association pledge its full support of the psychiatric program of the Veterans Administration, which Dr. Blain has done so much to develop.

The Council accepted the Budget Committee's report and authorized the investment of \$20,000 in United States Bonds and a percentage investment in Canadian Bonds.

A request from the National Conference on the Prevention and Control of Juvenile Delinquency for a contribution of approximately \$100 was approved in principle and referred to the Budget Committee for their consideration and recommendation.

The Council voted to accept the resignations of 49 members and to continue the memberships of 19 members and remit their dues.

The Council met on May 15 and 16, 1948, and approved recommendations of the Executive Committee: that the subscription rate of the JOURNAL be continued at \$3 for medical students; that an appropriation not exceeding \$100 a month be allotted for the necessary secretarial assistance of the President of the Association; to add Miss Eleanor Merrian to the staff at an annual salary of \$1,664 and to increase the salary of Miss Olga Naidach from \$35 to \$40 a week; that the office of Dr. Clarence B. Farrar in Toronto be officially design-

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nated as the Canadian Office of The American Psychiatric Association.

The Executive Committee reported that at a meeting with Dr. Daniel Blain on February 8, 1948, he accepted the appointment of Medical Director of the Association.

The Executive Assistant was authorized to sign a new contract with the Lord Baltimore Press for paper for the JOURNAL at a 20% increase over the cost in 1947.

The Council approved the dates of May 23-27, 1949, for the annual meeting in Montreal, Canada, providing there is no conflict with the American Medical Association.

The Council voted in favor of the Association acquiring new office space in the RKO Building, New York City, on the basis that if it is found desirable to move the office to Washington D.C., or elsewhere before the lease expires, there would be no difficulty subleasing the space.

The Council recommends that the subscription rate for the JOURNAL offered to medical students and interns, namely \$3, be offered also to first, second, or third year residents, according to the American Board plan.

The Council moved the establishment of a standing Committee on Alcoholism.

The Council recommends the adoption of the following resolution, to be conveyed personally to the Administrator of Veterans Affairs.

"Be it resolved that the Administrator of Veterans Affairs give consideration to the establishment in the Veterans Administration of a bureau type of organization, to the end that the Department of Medicine and Surgery may properly and adequately carry out its assigned mission, namely, operation of a complete medical and hospital service under the Chief Medical Director, who shall be responsible directly to the Administrator. This Bureau of Medicine and Surgery should be complete to the extent that it shall include those functions of operation and supply, personnel, finance, budget, and other organization elements necessary for the proper operation of hospitals and medical departments of regional offices, and such other functions as may be necessary to support these activities or may otherwise be assigned by the Administrator. The Chief Medical Director will then have complete authority as well as responsibility for the operation, control, and supervision of all activities involving medical examinations and treatment."

The Council moved that the report of the Special Committee on Psychiatric Principles and Practice be accepted with thanks and that the Committee be discharged. It further moved that the Chairman of the Committee on Ethics be empowered to confer with the Chairman of the Committee on Public Education and any other committees as he might see fit.

It was also moved that the Special Committee to Consult with the Chicago Branch of the American Civil Liberties Union and the American Bar Association, and the Special Committee Advisory to the New York State Department of Social Welfare, be discharged with thanks.

The Council recommends the adoption of the following proposed amendments to the Constitution:

Article III, Section VII.—Life Fellows shall be those who have maintained themselves in good standing for 30 consecutive years. This 30-year period shall begin at the time membership status was bestowed. They have all the rights of Fellows.

Life Members shall be those who have maintained themselves in good standing as Members for 30 consecutive years. They have all the rights of Members.

Article V. Privileges.—Life Fellows, Life Members, Honorary Members, and Corresponding members shall be exempt from the payment of annual dues to the Association.

It was moved, seconded, and carried that the report of the Council be adopted.

CHAIRMAN OVERHOLSER: You may remember that yesterday we sent greetings to Dr. N. Emmons Paine, our oldest living member, who has been a member for 61 years. He is now about 93 or 94. He has replied as follows: "Your precious greeting came. My fatherly good wishes for you and my associates. May the Lord bless you and keep you."

Dr. Garland Pace, the senior of the three Auditors, reports that he and his associates have seen and approved the report of the certified public accountant, which was presented here earlier.

Is there any other business to come before the meeting? The Secretary has an announcement to make.

DR. BARTEMEIER: I wish urgently to request that the secretaries of the sections do their best to give me the names of the new chairmen and the new secretaries of the sections sometime today.

CHAIRMAN OVERHOLSER: That concludes the business meeting. The banquet is this evening at 7:00 o'clock in this room, and the general session will convene tomorrow at 9:00.

The meeting adjourned at 9:40 a.m.

#### THURSDAY MORNING SESSION

MAY 20, 1948

The fourth General Session convened at 9:15 a.m., Dr. Overholser presiding.

CHAIRMAN OVERHOLSER: Will the meeting please come to order.

The first item of business is the report of the Committee on Resolutions. I will ask Dr. William B. Terhune to give the report.

Dr. Terhune read the report of the Committee on Resolutions.

CHAIRMAN OVERHOLSER: Presumably the last item in the resolutions, namely, consideration of the establishment of the Committee on Resolutions as a standing committee, would go to the Council for action. We will assume, therefore, that in

voting on these resolutions you are not voting on that particular item.

It was moved, seconded, and carried that the report of the Committee on Resolutions be adopted with exception of the recommendation concerning the status of the Committee.

CHAIRMAN OVERHOLSER: I should like to ask to stand and be recognized Dr. Paul G. Dame, of Australia, a fellow psychiatrist who is sojourning for a while in Washington.

Dr. Dame rose and was applauded.

CHAIRMAN OVERHOLSER: I will ask the Secretary if he has any further report.

DR. BARTEMEIER: The following amendments to the Constitution, which were presented to the membership last year, are proposed for action at the present meeting.

Article VI, add as follows, Section 4: "The Council may fill vacancies occurring among elected officers."

In Article VII, under Powers, our present Constitution states: "The President shall preside at the annual or special meetings of the Association or Council." The proposed amendment is to strike out "or Council."

The proposed additional amendment is: "The Council shall choose annually a Fellow of the Association as moderator to preside at all its sessions. In case the moderator be not a member of the Council, he shall have no vote."

DR. SAMUEL W. HAMILTON: Mr. President, in moving the adoption of the first amendment (to Article VI), I would remind the Association that at present there is no way of filling a vacancy, and as an illustration of a serious situation in which the Association might find itself, I mention the possible disability of the Treasurer. Should that occur today—unless this be adopted—there would be no person authorized to draw checks. I therefore move, sir, that this amendment to the Constitution be adopted.

CHAIRMAN OVERHOLSER: Dr. Hamilton moves the adoption of this first amendment, providing for the filling of vacancies among elected officers.

The motion was seconded by Dr. Karl Menninger, put to a vote, and carried.

CHAIRMAN OVERHOLSER: It requires a two-thirds vote of those present and voting for this purpose, and no one voted in the contrary. The next amendment provides that the President need not preside over the Council, but that there shall be instead a moderator.

DR. HAMILTON: In moving the adoption of these amendments which enable the Council year by year to elect its own moderator. I would remind the Association of what has been presented to you before, the fact that the President now has to sit hour by hour and day by day in the chair whenever

the Council meets, instead of having the freedom of movement which is often very helpful to him in bringing about the measures that he wishes. To be sure, under this amendment the President is under no disability; if he wanted also to be moderator, he could be elected moderator the same as anyone else, but I know, historically, that we have had Presidents, very able men, who would gladly have turned over the routine duty of presiding at Council meetings to someone else, but under the Constitution that was their responsibility.

This has no bearing on presiding at meetings of the Association, nor at meetings of the Executive Committee. This merely deals with Council meetings, but in the opinion of quite a number of us who have discussed this matter during the past two years, it would improve the operation of the Association. I therefore move, Mr. President, the adoption of these two amendments which enable the institution of the new procedure.

The motion was seconded by Dr. Frederick Allen and carried.

CHAIRMAN OVERHOLSER: I shall now ask Dr. Bartemeier to give the report of yesterday's Council meeting.

DR. BARTEMEIER: The Council met again on May 19, 1948 and approved further recommendations of the Executive Committee: that a resolution urging the adoption of the charter of the World Health Organization be submitted to the membership; that graduate students of psychology, psychiatric social work, and psychiatric nursing be permitted to subscribe to the American Journal of Psychiatry at \$3; that the question of establishing a joint committee of this Association and the American Hospital Association be referred to the Chairman of the Committee on Psychiatric Standards and Policies.

The Council recommends the adoption of the following resolution proposed by the Committee on Psychiatric Nursing:

"WHEREAS, The care and treatment of members of the Armed Forces disabled during World War II by mental or nervous illness was hampered and sometimes made ineffective by exclusion from the Nurse Corps of the Armed Services of men trained and experienced in such care, and

WHEREAS, The indiscriminate drafting of student and graduate nurses into nonnursing positions in the Armed Forces further handicapped already understaffed hospitals, interrupted the training of male nurses, and reduced their number to a dangerously low level, and

WHEREAS, There is serious need for a large number of adequately trained male nurses, particularly in our mental hospitals, civil and military, therefore

*Be it Resolved*, That student male nurses should be exempt from the draft, and that graduate male nurses should be deferred until such time as they are accepted into the Nurse Corps of the Armed Forces as commissioned officers."

The report was duly adopted.

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CHAIRMAN OVERHOLSER: There is one announcement that I would like to make. In my presidential address Monday morning I spoke of the Hofheimer Prize. I wish to say that the Prize Committee has met and has elected Dr. Nolan D. C. Lewis its Chairman. The membership is as follows: Dr. Franz Alexander, Dr. George E. Daniels, Dr. David M. Levy, Dr. Nolan D. C. Lewis, Dr. Thomas A. C. Rennie, Dr. George S. Stevenson, Dr. Harry C. Solomon, and Dr. John C. Whitehorn.

It is expected that a notice will soon be published, presumably in the JOURNAL, and that names will be submitted either by applicants themselves or at the suggestion of members, or of others, for consideration up to an announced deadline, and that the first award of \$1,500 will be made at the meeting a year hence. The prize is given for original contributions by persons under 40 in the field of research in psychiatry or mental hygiene.

This is the last business session of the meeting. Is there any further business to come before the meeting? If not, it is now my pleasure to turn the gavel over to my successor, who needs no introduction to you.

I deeply appreciate all the support that has been given to me and the courtesies that have been shown me during my tenures of office in this Association. I look forward to being at least moderately active in some of the doings of the Association even though I am now officially relegated to the group of has-beens.

It is a great pleasure to present to you the incoming President, Dr. William C. Menninger.

The audience rose and applauded.

PRESIDENT-ELECT MENNINGER: *Members of the Association:* I think quite naturally you may be interested in looking forward, with what ability we can, to crystal-gaze, to this coming year which I hope will be a prosperous one for the Association and for psychiatry.

I would like to say a few words of some hopes and plans. First, I believe our big challenge, if we can do so, is our plan for reorganization. I think that is a matter of individual responsibility of all of us wherever we live, because this will not happen unless those of us in each area take the initiative to bring it about. The Council is very desirous of being of help in any way it can, under the leadership of the Reorganization Committee, and with the help of our Medical Director.

We are hopeful that our 32 committees may have a chance to be much more active this coming year than they ever have been. The Council and the Budget Committee have given them the sum of about \$25,000 to function this coming year. They are currently about 95% set up and ready to go.

It is hoped that for the first time we can try the experiment sometime during the year of having all the committees meet simultaneously together, with the hope that we can get more integration among those committees' functioning by their meeting at the same time.

We anticipate a great deal of benefit from the establishment of a Newsletter that will go to all the membership, carrying current information of what is going on in psychiatry and what affects psychiatry. We would hope that it would carry news about these committees, about the affiliate societies, and about what is going on in government that concerns psychiatry. Many of us feel that our functioning is largely dependent on the effectiveness of our communication system; without information, obviously, we cannot act. We hope that it will materially increase the effectiveness of the Association.

Last, I would pay special tribute to our affiliate societies, because while the Association as a large national group is powerful, much of our power depends on the grass-root situation. I am sure that our affiliate societies, if given jobs, would be delighted with the opportunity to carry them out. I have had very gracious offers from almost all of these affiliate societies to be of help in any way requested by the Council or the Executive Committee; and I fully intend to give rather large chores, very big challenges, I hope, to the affiliate societies to work on in addition to what happens in our committees and with the organization as a whole.

I feel a great sense of humility in attempting to take on this enormous responsibility. I have said publicly more than once that it seems to me that psychiatry is at something of a crossroads. Whether we are big enough to rise to the challenge is yet to be seen, but I can assure you that those of us who have the responsibility for the society will devote ourselves intensively and sincerely to trying to carry psychiatry to the greatest possible heights. Thank you very much for the honor in placing me at this helm.

CHAIRMAN OVERHOLSER: I should like to ask the incoming President-Elect, Dr. George S. Stevenson, of New York, to come to the platform.

DR. GEORGE S. STEVENSON: I think that one can best understand my feelings in assuming this prospective responsibility in terms of three days. As I think back upon Monday, I think back on a feeling which had within it an appreciation of an honor merely to be thought of as one who might be helpful to you in carrying out the things that I know you want carried out.

As I think back on Tuesday, I think of an even greater satisfaction that can come from knowing that 5%, 4%, even 2% of a membership is behind one, whether one is given an eventual responsibility or not.

And then as I think of Wednesday, I think of the things that perhaps have not been done in the past, the things that Bill and I can get our heads together on, with the rest of the Executive Committee, during the coming year, and I think of that with a good deal of humility and knowledge of a big job to be done. And so I trust we shall be working together to see that these things are carried through.

CHAIRMAN OVERHOLSER: The Secretary has one other announcement of interest.

DR. BARTEMEIR: The registration as of 6:00 p.m. yesterday was: members, 1,481; guests, 1,529; total registration, 3,010.

CHAIRMAN OVERHOLSER: It may interest you to know that although there may be a few more registering this morning, late, we are already Number 2 on the list of attendance for our meetings for all time. The only one to have exceeded this

number is the New York meeting of last year, where there were many more guests. There the registration was approximately 3,600.

Is there any further business to come before the meeting? If not, I will declare the meeting adjourned.

The meeting adjourned at 9.50 a.m.

*Editor,*

SIR:

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## CORRESPONDENCE

### ELECTION OF OFFICERS

March 31, 1949.

*Editor, AMERICAN JOURNAL OF PSYCHIATRY:*

SIR: May I request the liberty of your pages to express a concern, which many others share, about developments which have taken place in the Association during the last two or three years. Within that period we have seen growing dissension between the members, the conversion of the Annual Meeting into a political arena, and the appearance of highly organized and financed pressure groups which are threatening the continued unity of our Association.

Many of us are alarmed by the possibility that the Montreal meeting may become a final battleground for those opposing groups and have searched for ways in which to prevent serious damage being done both within the Association and in the eyes of the public.

I should like to make two simple remedial proposals for the consideration of the membership:

- I. That no member should be elected to office in the Association who at the same time holds membership in a pressure group.

The membership at large, if determined on this point, can readily ensure the defeat of those standing for office who propose to represent, at the same time, The American Psychiatric Association and some pressure group.

- II. That the Reorganization Committee be thanked for service, and dissolved. Unfortunately, despite a great deal of devoted work and extensive planning, feelings have begun to run so high concerning this committee that it seems unlikely that any proposals it might make would receive the thoughtful consideration which they might deserve.

In its place, the incoming President should set up a Committee on Constitution, the members of which would be subject to all the limitations in tenure of office imposed upon other standing committees. This Committee would function continuously over the years to bring proposals for change before the members, and thus serve to prevent the building up of periods of stress—of which the present is an alarming example.

D. EWEN CAMERON, M. D.,  
McGill University,  
Montreal.

## PRESIDENT'S PAGE

As this is written, our Montreal Meeting is just two months away. As you read this it will be just two weeks—if that much—away, but even now, two months in advance, Montreal promises to be one of the memorable meetings of our Association. The fact that it will be in Montreal is undoubtedly a very special attraction for many of us from the states. For our Canadian members it will be looked upon with special satisfaction because we do convene in their country.

Even now in March, there have been over 1,750 reservations requested and a scramble is on for hotel rooms. In addition to the attractiveness of having a meeting in Montreal, the promised large attendance must in part be due to the keen and active interest of the members in our Association. This is evident on many sides. Every one of the 28 committees has been and is very active; many of them will have special reports to the membership in the course of the meeting. Others will conduct round-tables and open committee meetings for any members interested.

Numerous special features of the meeting are indicative of the activities within the Association. There will be 2½ days devoted to hospital administrative problems and there is a good chance that an administrative section may be organized in the Association. There will be a round-table for members who are concerned with the integration of psychiatry into the state medical societies. Further, there will be a special round-table of members working in and interested in college mental hygiene. There is some agitation for a section for those individuals interested in private psychiatric hospitals.

In addition to the work of our committees, the Executive Committee, and the Council, our Central Inspection Board has gotten on the job with the appointment of a full-time director, during the past year. The affiliate societies have been active. We have previously had 18 affiliate societies and at this meeting 7 more will make application—Texas, Northern California, Indiana, Iowa, Milwaukee, Nebraska, and Washing-

ton, D. C. It has been my privilege to meet with more than half of these groups during the past year.

Undoubtedly the consideration of the Reorganization Plan, which will be given an entire morning, will be a highlight in the meeting. A representative of the Reorganization Committee will give this committee's report. A representative from the Committee on the Preservation of Medical Standards in Psychiatry has been asked to give comments from that group. Each of the affiliate societies has been invited to send a representative to express the opinions of those groups. As has been well publicized, the original proposal of the Reorganization Committee at the Washington meeting of the Association will not be voted on, on the recommendation of that committee to the Council, which was accepted. There is, furthermore, a legal technicality in that the proposed Constitution as presented at the Washington meeting differed in some details from that published in the JOURNAL. Undoubtedly there will be many suggestions and very possibly amendments presented by various groups.

All of this activity is undoubtedly healthy. Most of us are aware that we live in a turbulent time and some of this turbulence is even evidenced in our Association. It too may be healthy. Growth, and particularly when it is rapid, never takes place without presenting problems and few real or worthwhile problems can be solved without a struggle. Each of us, however, has the obligation to solve these problems and differences in such a way that the strength and solidity and unity of the Association must be maintained. There is no reason why this should preclude special subsidiary societies which would be vehicles for special group interests or special missions. On the other hand, every effort must be made to maintain an over-all national organization as our medium with which to do business with the public.

WILLIAM C. MENNINGER, M. D.

## COMMENT

### NOSOPHOBIA, NOSOPHILIA

Reading habits of the people, as revealed by borrowings from public libraries, are in some measure an index of the general state of mind and of trends of public consciousness in wholesome or unwholesome directions.

There are features in some recent reports of reading trends furnished by the American Library Association that are not reassuring.

With the outbreak of war and through the war years the general interest of the reading public in religion took a sharp swing upward. This is a well-known psychological pattern in times of great stress and mass personal bereavement. One recalls the spiritistic crusades of Sir Arthur Conan Doyle and Sir Oliver Lodge following World War I.

From reports of public libraries across the country in 1944 the American Library Association concluded that the average person was interested in his own personal problems first and in the war and the state of the world second. His interest in religion had not slackened. Let us keep in mind as we go on this tendency to introspection and self-concern.

In 1946 the A.L.A. noted that psychological stories such as "The Snake Pit" were increasingly popular and were responsible for requests for books on psychology and psychiatry. "People in general," the A.L.A. reported, "are turning toward books of information that give individuals help with their particular problems." This may seem a natural and healthy reaction, but let us for the moment leave the question open.

A survey of reading trends reported in 1948 still showed that the average American reader was interested first and foremost in his personal problems, then housing, and third, business; that he was not much concerned about international troubles; and that his interest in atomic energy was almost nonexistent (on this latter point one librarian referred to the ostrich legend). The A.L.A. found that psychology books were in tre-

mendous demand, out of proportion to other classes of literature. The consensus was that this increased urge to read books on psychological subjects was caused not only by general world unrest and uncertainty but also by the current popularization of psychiatry by motion pictures, the radio, and the spate of texts that have flooded the market in recent years. It was recorded that quite commonly doctors were prescribing on prescription blanks books on psychology for troubled patients to use as medicine. One librarian reported numerous requests for a book "to believe in and live by."

The number of books, written by persons qualified or not, currently issuing from the printing houses, explaining to the "intelligent layman" (poor soul!) how his mind works and how he can make it work better, build up his personality and make friends of influential people, etc., is somewhat alarming. Occasionally one has the disquieting suspicion that some of the scientists, pseudoscientists, or inspirationists who wrote these books are simply cashing in on the wave of psychomania that is a manifestation of our time. In a recent issue of the Sunday book review section of the *New York Times* were advertised 18 separate works in the general field we are talking about. Among these were 2 or 3 probably worth-while psychiatric texts; the others looked like pot-boilers calculated to attract attention on the best-seller counters. Along with those giving off a faintly scientific emanation were the various perennial do-gooders of the Dale Carnegie stamp which offer to change your inferiority complex into a Caesar or Messiah complex at so much per.

So far as the present writer's observation goes the practice of recommending or prescribing for patients texts dealing with mental processes, normal or abnormal, is to be condemned. Not only can the reading of such a book not take the place of a planned individual rehabilitation program, but it may be positively harmful, adding to the symp-

toms the patient already has. I recall one patient who brought in one of these self-cure manuals studded with question marks at scores of passages that had aroused new fears in his mind. The first item of treatment was to deposit the proffered book gently in the wastebasket.

An incident like the foregoing—and it is by no means an isolated case—illustrates the iatrogenic potential of books psychiatrists and fellow travelers write for popular consumption, and raises the question whether it is not about time that a moratorium on such literature should be declared in the interests of a long-suffering public.

In our well-meaning efforts to promote mental hygiene, expose and correct unsuitable conditions in psychiatric hospitals, and improve the care and treatment of mental patients, we may easily fall into the error of disregarding both the nosophobic and nosophilic propensities of a considerable segment of the population. On the one hand, if we continue to frighten people by repetitiously telling them that 1 in every 10 will need psychiatric care sooner or later, we may be uttering more or less true prophecy, but is it good preventive medicine? And on the other hand, by extending indefinitely the boundaries of the concept of illness to include all or much that may be more prop-

erly subsumed under the heading "poor morale," are we not encouraging those with undue capacity for "enjoying poor health" to indulge the unprofitable propensity?

Professor Ryle of Oxford chose "Nosophobia" as the subject of his Maudsley Lecture in 1947. He stressed the ubiquity of this disorder and its not infrequent iatrogenic nature. Said he: "Fears of disease are widely engendered through the advertisements of proprietary medicine; by the outpouring of ill-judged medical articles in the lay press, of a type even more familiar, perhaps, to American than British readers; and by unorthodox practitioners." Fund-raising campaigns in the interests of heart disease and cancer research also have their seamy side. As Ryle pointed out, cancer phobia without cancer is much commoner than cancer phobia with cancer. In a crowded Fifth Avenue bus in New York City there was recently observed a conspicuous advertisement carrying the cheerful announcement in large letters: "Every Three Minutes Some One Dies of Cancer." In cultivating its field of cure and prevention of disease and promotion of health, medicine, including psychiatry, needs to be more rigidly on guard than has too often been the case against exerting pathogenic influences.

### GENERAL SEMANTICS

The following remarks summarizing the development of general semantics were made by Count Alfred Korzybski at a luncheon given in his honor by Robert U. Redpath, Jr., at Yale Graduate Club, New Haven, Conn., on January 31, 1949.

"In general semantics we are not concerned with physics or with mathematics as such. What we are concerned with is *physico-mathematical method*, which a layman and even a child can understand. This method happens to be a higher order abstraction, a digest from *both* physics and mathematics, which is applicable by human beings everywhere in daily life.

"My work began, as you may know, by formulating a unique human function, which I call 'time-binding.' Through observations and study it became obvious to me that

human beings represent a 'time-binding class of life,' since they have the potentiality at least to transmit accumulated achievements from one generation to the next, so that each generation can begin where the former left off. Each generation does not need to learn all over again by bitter trial and error but can stand on the shoulders of those who have gone before. Animals cannot do this, nor can plants. The formulation of this natural, characteristically human function gives us the means to discriminate sharply between man and animal, and leaves no need for zoological or mythological evaluations.

"I followed this by many years' study of what men actually *do* as time-binders. I came to a conclusion that in mathematics and exact sciences human nervous systems are working *at their best*, and that what they

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are doing when they 'mathematicize' is simply making structural patterns ready for application to actual human life issues. It is not surprising then that we should find physico-mathematical methods especially useful in dealing with human affairs generally.

"As a summary it may be said roughly that from 'pure' mathematics, which was not supposed even to be a science as it lacked empirical content, we established 'applied mathematics,' which dealt with empirical results. In my work I had to pass to a third step; namely, the simplest crystallization of physico-mathematical *method*, which also involves empirical results, but this time on the human daily life psycho-logical level of evaluation.

"In closing I want to say something about the present tragic world situation. We are compelled now to rearm at enormous expense because East and West simply have no way of understanding each other. There is no way out, short of a Third World War, which will happen, *unless* we can agree on common human-scientific premises for our

orientations about 'man.' Dictatorships, 'iron curtains,' as long as they remain, will always make this impossible, as they are clearly against time-binding. There is, however, something that can be done. We can bring the peoples that we are in communication with to a common understanding of man's natural time-binding function; we can continue to produce solid human-scientific data on which all can agree, and the Soviets definitely cannot win against a united public opinion.

"I should point out that I say 'Soviets' deliberately since actually there is no such thing as 'Russian.' What is commonly called 'Russia' is not a melting pot like the United States, where separate cultures have blended to produce a new, higher culture. 'Russia' is a mixture of tribal cultures, each keeping its individuality. From these there cannot spring a world-wide movement for peace and social progress until there is a common understanding of men's natural functions as time-binders."

## NEWS AND NOTES

**COMMONWEALTH FUND.**—The 1948 annual report of the Commonwealth Fund indicates that support is being given to medical schools which are trying to bring psychiatry into teaching partnership with departments of medicine and pediatrics. The most concentrated effort of this kind is the "pilot clinic for a broader medical service" at Cornell University Medical College, where six advanced fellows in medicine are receiving training in the care and study of patients whose physical symptoms are associated with emotional difficulties.

Other undertakings of similar purpose are under way at the University of Cincinnati College of Medicine, Harvard University, and the Long Island College of Medicine. In the latter institution, the department of psychiatry is integrating its teaching program with the medical curriculum as a whole and is helping students to think in terms of patients rather than in terms of diseases.

**STRONG MEMORIAL HOSPITAL, PSYCHIATRIC CLINIC.**—A dedicatory program for Wing R Psychiatric Clinic of Strong Memorial Hospital and the University of Rochester (N. Y.) School of Medicine and Dentistry was held on March 31, 1949 at the University. The speakers included Professors Clyde Kluckhohn (anthropology), Howard Liddell (psychobiology), Homer W. Smith (physiology), and Paul Weiss (zoology), in addition to Dr. George H. Whipple, Dean of the School of Medicine and Dentistry, Dr. John Romano, professor of psychiatry, University of Rochester, and Dr. Lawrence S. Kubie, clinical professor of psychiatry, Yale University. Provost Donald W. Gilbert of the University of Rochester presided at the morning session and Dr. Romano at the afternoon session.

**DR. O'NEILL DIRECTOR OF UTICA STATE HOSPITAL.**—The appointment of Dr. Francis J. O'Neill as director of Utica State Hospital, effective April 1, 1949, has been announced by Dr. Frederick MacCurdy, State Commissioner of Mental Hygiene.

In accepting his appointment at Utica, Dr.

O'Neill will take over the operation of the oldest mental institution in the state system, established more than 100 years ago. He has been assistant director of Central Islip State Hospital since 1946, having entered the state service at that hospital in 1933.

Dr. O'Neill is a native of Vermont and graduated in medicine from the University of Vermont in 1932. He served in the navy from December 1941 to 1945, in the Southwest Pacific. He was released from active duty with the rank of commander. He is a diplomate of the National Board of Medical Examiners and of the American Board of Psychiatry and Neurology.

**DR. BRACELAND APPOINTED TO FORRESTAL COMMITTEE.**—Announcement has been received of the appointment of Dr. Francis J. Braceland of the Mayo Clinic to the Armed Forces Medical Advisory Committee, commonly known as the Forrestal Committee. The function of this very important committee is to consider all the medical problems of the Armed Forces with a view toward unification of the services. Chairman of the committee is Mr. Charles Proctor Cooper, the president of the Columbia Presbyterian Hospital group.

**GRADUATE COURSE AT LANGLEY PORTER CLINIC.**—A postgraduate course of 12 weeks in psychiatry and neurology will be offered at the University of California Medical School (The Langley Porter Clinic), in San Francisco, August 29 through November 18, 1949, full time, under the chairmanship of Dr. Karl M. Bowman, professor of psychiatry, University of California. The fee will be \$200. For program and information write to Dr. Stacy R. Mettier, University of California Medical Center, San Francisco 22, Calif.

**PSYCHIATRIC FILMS.**—The New York University Film Library announces a series of psychiatric films on integrated development for the profession. These films were taken at the New York Infirmary under the direction of Dr. Margaret E. Fries, psycho-

analyst. The scenes in the films start with birth and continue until the tenth year of life. The psychiatric material is integrated with the physical and sociological. The case history also has the findings of the Rorschach done by Zygmunt Piotrowski. Brief guides accompany each film. For information write to Dr. Margaret E. Fries, 26 Washington Place, Annex Building, New York, N. Y.

#### SIN AS A CAUSE OF MENTAL ILLNESS.—

In an interesting discussion of "Attitudes and Opinions Concerning Mental Illness," in the *Psychiatric Quarterly* for July 1948, Ramsey and Seipp comment on various opinions held by adults on the basis of personal interviews with 345 individuals.

From the standpoint of education, replies to the question, "Do you believe insanity is God's punishment for sin?" were in the affirmative with or without qualification in 41% of those of education level from 0 to grade 4; 26% of those from grades 5 to 11; and 7% of those who had attained grade 12 or upward.

On the occupational basis affirmative replies were received from 32% of the laboring class, 10% of the white-collar group, and 0% of the professional and executive group.

A comparison of Negroes and whites gave affirmative replies in 50% of Negroes and 17% of whites.

#### 1949 COURSES IN GENERAL SEMANTICS.—

The sixth annual seminar-workshop course in non-Aristotelian method and general semantics will be held at the Institute of General Semantics, Lakeville, Conn., August 14 to September 6.

"Time-Binding and the Improvement of Human Evaluation, Communication, Social Relations, and Scientific Advance" will be the theme of the program, which will include 40 hours of training lectures by Count Korzybski. Other eminent authorities will deal with various branches of the subject. Three scholarships for this course will be awarded, one of them to a psychiatrist.

Enrollment is limited to 40. Applications, accompanied by \$50 registration fee, should be sent at once to the Institute of General Semantics, Lakeville, Conn.

**CARNEGIE CORPORATION.**—The election of John W. Gardner as vice-president of the Carnegie Corporation of New York has been announced by Charles Dollard, president. A former professor of psychology, with a Ph. D. degree from the University of California, Mr. Gardner has been largely responsible for planning and executing the Corporation's expanding program in the field of the social sciences. He has been an executive associate of the Corporation since 1946.

**WHO MENTAL HEALTH PROGRAM FOR 1950.**—The first international program of mental health has been approved by the WHO executive board and will be submitted to the Second World Health Assembly meeting next June in Rome. The program includes collection and dissemination of information, field surveys and team demonstrations of methods of survey, prevention, and treatment of mental disorders.

It is contemplated that the field surveys will be devoted to mental health problems in rural communities, in industrial units, and among students, these being three fields in which comparatively little work has been done to date.

**VA RESIDENCIES IN BOSTON.**—Several openings for residency training in neuropsychiatry are open for July 1, 1949, in veterans' hospitals and clinics in Boston, Framingham, Bedford, and West Roxbury, Mass., and White River Junction, Vt. The training program, which may be 1 to 3 years, is under the direction of the Deans of Harvard, Tufts, and Boston University Medical Schools and includes inpatient, outpatient, and child psychiatry and neurology.

Information may be obtained from Dr. J. L. Hoffman, Bedford VA Hospital, Bedford, Mass., or from Dr. Wilfred Bloomberg, Cushing VA Hospital, Framingham, Mass.

**DR. PORTEOUS DIES.**—One of the senior Fellows of The American Psychiatric Association and one of the three Life Fellows from Canada, Dr. Carlyle Arnot Porteous, died at his home in Montreal, March 14, 1949, at the age of 72.

Dr. Porteous' early choice of psychiatry

as a career is indicated by the fact that he became a member of the A.P.A. in 1905, four years after his graduation in medicine. He served many years on the staff of the Verdun Protestant Hospital in Montreal, was assistant superintendent under Dr. T. J. W. Burgess of that institution, and at length succeeded Dr. Burgess as superintendent. He retired in 1947.

He was one of the pioneers in Canada in the use of the shock therapies, and by making his hospital available for clinical instruction he contributed significantly to medical education in Quebec. He was also sought after in medicolegal work, for which his extensive experience and mature judgment preeminently fitted him.

His successor, Dr. George E. Reed, comments: "Patients, relatives, the hospital staff, and many people in the community admired Dr. Porteous because of his good judgment that even in most difficult circumstances was tempered by a kind courtesy."

**ANTIVIVISECTION MEDDLING.**—Dr. A. C. Ivy, vice-president of the University of Illinois and recently re-elected secretary of the National Society for Medical Research, reports that the Society will have to continue its fight against the antivivisection group, which seeks to undermine the foundations of all medical progress. Legislation to outlaw animal experimentation is pending in a number of states and if passed would "throttle all medical research and teaching in those localities."

Dr. Ivy added, "A small but fanatically active minority of antivivisectionists has been winning small but cumulative victories over the last half century which a few years ago threatened research in this country aimed at the conquest of cancer, heart disease, polio, and other dangerous maladies." While the mischievous activities have caused temporary abandonment of certain important research projects, a wider public understanding of the methods of medical research has been favorable and medical progress has been resumed.

**NEW DEPARTMENT AT TULANE UNIVERSITY.**—President Rufus C. Harris has announced the establishment of a depart-

ment of psychiatry and neurology in the School of Medicine at Tulane University, which will provide both undergraduate and graduate training. The graduate course in neurology or psychiatry for qualified physicians covers a 3-year period with psychoanalytic training option. Dr. Robert G. Heath, formerly of Columbia University, is head of the new department.

**WESTERN INSTITUTE ON EPILEPSY.**—The first Western Institute on Epilepsy will meet in Denver at the University of Colorado Medical Center, May 16-18, 1949. Members of the medical profession, as well as social workers, psychologists, and interested laymen, are invited to attend. Lectures, clinics, and round-table discussions on epilepsy will be held, with Dr. Jerry Price of the Neurological Institute as keynote speaker. Institute fees will be \$5.00. For information address the Director, Epilepsy Service, University of Colorado Medical Center, Denver, Colo.

**FELLOWSHIPS IN CHILD PSYCHIATRY.**—The Child Center of the Department of Psychology and Psychiatry, Catholic University, Washington, D. C., announces two fellowships (grants: \$2,400 for 11 months, and \$1,600 for 8 months) in child psychiatry for physicians who have completed one year of internship and one year of psychiatric training under supervision approved for the American Board of Psychiatry and Neurology.

Further information may be secured from the Medical Director, Dr. Robert P. Odendwald, Child Center, Catholic University, Washington, D. C.

**AMERICAN PSYCHOPATHOLOGICAL ASSOCIATION.**—The annual meeting of this Association will be held at the Commodore Hotel, New York City, June 3 and 4, 1949. The program will consist of a symposium on *Anxiety*. There will be 4 sessions: clinical, psychological, physiological, and social-anthropological.

Correspondence may be addressed to the chairman of the program committee, Dr. Joseph Zubin, 722 W. 168th St., New York 32, N. Y.

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## BOOK REVIEWS

PRACTICAL CLINICAL PSYCHIATRY. By Edward A. Strecker, M.D., Franklin G. Ebaugh, M.D. and Jack R. Ewalt, M.D. Section on PSYCHOPATHOLOGIC PROBLEMS OF CHILDHOOD by Leo Kanner, M.D. (Philadelphia: The Blakiston Company, Sixth Edition, 1947.)

The first edition of this textbook of psychiatry appeared in 1925. The fifth edition appeared in 1940 just before the war. The present edition, therefore, includes all the revisions and changes that have happened in psychiatry during the past 7 years.

The general material of this book has undergone no rabid or extreme changes. The approach to mental diseases is the same, following in general the formulations of Adolf Meyer, to whom the book is dedicated. Illustrative case histories are given throughout and a fairly extensive bibliography is included at the end of some chapters.

The drastic therapies are treated rather briefly. The authors in general seem to feel that insulin in schizophrenia and electroshock in depressions and involutional melancholia are of considerable value. It is to be noted that only one page is given to "surgical procedures in the treatment of psychoses." One is a little disappointed with such a brief discussion of this controversial question, but realizing that the book appeared in 1947 and presumably the manuscript would have to be in the printer's hands in 1946 it is understandable why no more attention is paid to this subject. Electrocortical is not mentioned.

One chapter of 5½ pages is devoted to psychosomatic medicine. The following paragraph from this chapter should be required reading for all medical students and for the medical profession generally.

"The accomplishments of psychosomatic medicine are noteworthy; its object is magnificent, but the name is unfortunate. Its comparatively recent usage makes it sound like the announcement of a marriage between body and mind, with the subdivisions and specialties of medicine and psychiatry in the bridal party. If the union of body and mind has just been consummated then psychiatry for some time has sanctioned an illicit relationship. Long before the word psychosomatic was compounded, psychiatry had insistently taught that man was a total and indivisible unit and, therefore, in health and disease, every somatic process at once reverberated in all of the man and notably in his emotions; conversely that every emotional reaction, whether it was violent and pathologic, like rage, or merely a feeling tone, like a mild state of satisfaction, immediately had repercussions in every tissue and cell of the body."

A 25-page chapter on Psychopathologic Problems of Childhood by Leo Kanner is a good gen-

eral summary of this subject. A number of illustrative cases are included.

There is a 4½-page glossary. Many ordinary psychiatric words are included, and some of the definitions for other words might be questioned. It hardly seems necessary to include the following terms with their definitions: Disrobing—Taking off clothes; Panic—An intense fear state, associated with anxiety; Sadness—The feeling of grief or sorrow; Suicide—Taking one's own life; Tremor—An involuntary tremble. A careful revision of this glossary is suggested.

In conclusion, it should be said that this is an excellent textbook suitable for use by medical students. It will undoubtedly continue to enjoy its well-earned popularity.

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CHILDHOOD AND DEVELOPMENT AMONG THE WIND RIVER SHOSHONE. By D. B. Shimkin, Ph.D. (Berkeley: Anthropological Records, Vol. 5, No. 5, 1947.)

This is a brief account of several phases of the life of an American Indian tribe of the western plains as that life was carried on between about 1825 and 1875. The data for the monograph were collected from the testimony of old men and women who could recall the old ways.

As anthropological works frequently do, this monograph serves to illustrate the possible variations in the cultural matrix of individual behavior. Thus marriage is depicted in Shoshone mythology as a "... lustful, bitter relation, ever with the possibility of murder by either spouse." In striking contrast is the tenderness of love between brothers. When a man died there was usually the suspicion that the widow had committed the murder by witchcraft. A life history of an old woman, who had been married three times, tells how greatly she hated each of her husbands in turn, especially just before she married them.

Such departures from the ideal patterns of the culture in which most psychiatrists participate are not, of course, confined to the exotic customs of extinct societies. The Shoshone concept of the marriage relationship is shared by more than a few individuals and by some subgroups within the larger Euroamerican society. The Shoshone example and others from the literature of anthropology remind the psychiatric therapist that the "normal" situation to which his patient must adjust differs from group to group, and that any rigidly defined notion of normality invariably turns out to be abnormal from the point of view of another social group.

Dr. Alan Gregg and others have recently stressed the importance, for the practice of psy-

chiatry, of understanding normal variations, of knowing the cultural setting within which the behavior of the patient is manifested. Psychoses and neuroses, insofar as we now know, occur in the social life of every society. Shimkin cites several such cases among the Shoshone. In that sense, then, aberrant states are normally to be expected in every society, though expressed in different ways and of varying degree of incidence. Because the symptoms exhibited by psychotics have the effect of detachment from the reality of social life, it does not follow—as is sometimes assumed—that the etiology of the psychosis is also somehow divorced from society. On the contrary, aberrant mental states are to be understood as potentialities latent in each member of society, which indeed are manifested in attenuated form in everyday response to various situations and which appear as classic formulations of aberrancy as a final resort for the individual.

Shimkin's fine work with the Shoshone, of which this paper is only part, is part of a growing literature on the dynamics of various types and varieties of normality. Out of such studies there well may come a more powerful understanding of the dynamics, types, and varieties of social abnormality.

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CHILD PSYCHOLOGY. By *Arthur T. Jersild*. (Third Ed.) (New York: Prentice Hall, 1947.)

Students and teachers will find Jersild's third edition a comprehensive, well-integrated textbook, simply and clearly written, discussing the present knowledge in the field of child psychology. Like the 1940 publication, this volume follows the pattern of arranging the subject matter into topics, making it readily available for reference. Although basically the organization is very much the same, there is considerable improvement in various areas. Included are recent studies and thinking in the field of child psychology, with expansion and revision of bibliographies; changes in various chapter titles; and many additional sub-divisions. The chapters, in the previous edition, on "Emotional Development" and "Pleasure, Affection, and Sympathy" are at present incorporated in the presentation of "Feeling and Emotion"; on the other hand, there are now two divisions for the section on "Growth and Understanding." The chapters cover such topics as the beginnings of behavior, general characteristics of development, motor, social, emotional, and language development, growth of understanding, children's interests, intelligence, and problems of adjustment.

In the present volume, Jersild is more sensitive to the thoughts and feelings underlying a child's behavior, thus exploring basic motivation of behavior. He gives greater weight to the importance of the cultural milieu surrounding the child and to relationships, parental and otherwise, as powerful factors in the development of the individual. He integrates more fully the many factors of develop-

ment, displaying more clearly the interrelationship between forces in the growing child.

Jersild's method is to present the research material in the field, and although he does not reveal his own interpretations and thinking too readily, he frequently injects challenging bits of wisdom that enable the student to be cautious in digesting a particular point of view. For example, in his discussion of sibling relationships, he warns that "generalizations concerning the development of affection between siblings are likely to be especially misleading if they are based upon the testimony of maladjusted adults or upon the study of children who are being treated for severe symptoms of jealousy or other behavior problems." He states that "the course of the development of the normal child's affections for his brothers and sisters has not been studied systematically from the developmental point of view over a period of months and years."

This book is primarily geared to students and teachers rather than psychiatrists and clinical psychologists, since it does not delve into abnormal behavior and treatment, which the author specifically states is not the purpose of the book. Nevertheless, this volume is a valuable contribution to an understanding of basic child psychology.

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MAN, WEATHER, SUN. By *William F. Petersen*, M.D. (Toronto, Canada: The Ryerson Press, 1947.)

*Man, Weather, Sun* is a new attack on the problem of the effects of weather on man's health. It essentially comes to the same conclusions reached in the author's previous monumental work on "The Patient and the Weather." The defects of this monograph are similar to those that have been mentioned by previous reviewers of those volumes. A tremendous number of observations, anthropometric, biochemical, psychologic, etc., have been made on healthy triplets, psychotic patients, whole populations, and patients with scarlet fever, epilepsy, tuberculosis, etc., and these have been correlated with complex curves representing changes in barometric pressure and temperature. Special points have been chosen on these curves and detailed statistical correlations worked out. It is extremely difficult to interpret the charts and the author's choice of data for statistical treatment does not clarify the situation. Dr. Petersen makes little attempt to evaluate the times when shifts in weather did not correspond with changes in his experimental subjects. The author apparently realizes that this work will not satisfy his scientific colleagues. On page 43 he points out that the work is inaccurate from the point of view of the geneticist and the methods of testing the quality of personality will not satisfy the psychologist. Again he states the physiologist will be dissatisfied because the environmental factors have not been sufficiently isolated to make satisfactory correlation with physiological variables possible. And finally the meteorological data are not presented in

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a fashion to satisfy a meteorologist. There is no doubt that there is a basis for the author's contention that animals and the weather are subject to natural laws of periodicity and that there may well be a correlation between the sun and the weather and human behavior. He has failed, however, in supporting these hypotheses in rigorous scientific fashion. Dr. Petersen discusses many fascinating subjects such as body habitus, lunar axis and suicide, the vicissitudes of things, blood pH level and terrestrial magnetic activity, the rhythm of the cosmos, chaos—vortex—tongue. He concludes that in our region of the world, weather governs the well being, the moods, illnesses, and death of man. He offers many hypotheses explaining the mechanism of these relations.

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**FORTY-FOUR JUVENILE THIEVES: THEIR CHARACTERS AND HOME-LIFE.** By *John Bowlby, M.D.* (London: Bailliere, Tindall and Cox, 1946.)

This very interesting and illuminating 56-page monograph, by Dr. Bowlby of the London Tavistock Clinic, was originally published in the *International Journal of Psycho-Analysis* in 1944. It reports the intensive analysis of 44 child guidance clinic cases involving stealing, balanced by an equal number of clinic children who did not steal.

The approach in this study was very thorough and comprehensive, with the outstanding finding the apparently close correlation between delinquency, especially stealing, and prolonged separation (6 months or more) from the mother, or foster mother, during the first 5 years. This experience the author concludes to be definitely of specific etiologic importance. Furthermore, it appears to be productive of a special type of personality pattern which Bowlby terms "affectionless," that is, "characterized by lack of normal affection, shame or sense of responsibility." All but one of the children of this type were serious offenders, the majority truanting as well as stealing. Moreover, as a group, they constituted the majority of the really serious delinquents for the entire series. In addition, Bowlby feels there is a certain connection between the "affectionless character" and sexual offences. Since this type of makeup may be diagnosed by the age of 3, a plea is made for early evaluation and therapy. Also, preventively, the author stresses the need for proper awareness of the malignant potential of early prolonged parental separation.

This work, the reviewer feels, is a real contribution and certainly merits careful reading, particularly by those primarily concerned with children's problems.

T. R.

**HYGIENE.** By *Florence L. Meredith, M.D.* (Philadelphia: The Blakiston Co., 1946.)

In this fourth edition the author, professor of hygiene and public health at Tufts College, brings

her well-known general hygiene text thoroughly up to date. Of good format, comprising 838 pages and implemented with a special supplement dealing mainly with foods, also an adequate bibliography and index, the book is intended especially for college students. However, it should be useful too as a reference and source volume for intelligent laymen generally. In it health and ill health are approached from both the personal and social or public points of view and in a thoroughly integrated and effective manner. The last section, consisting of 5 chapters (79 pages), is devoted to mental health. This section, couched in very elementary terms and by no means as complete or always as definitive as might be, nevertheless covers the field in a direct and informative way. While hardly its strongest section, this portion does round out the volume and affords at least a beginning or introductory orientation.

T. R.

**MEN, MIND, AND POWER.** By *David Abrahamsen.* (New York: Columbia University Press, 1945.)

This book of 155 pages by the author of *Crime and the Human Mind* is an attempt by means of psychoanalysis to explain the psychology of the German nation and more particularly the psychology of the Nazi leaders and collaborators. The author outlines the life histories of Hitler, Goebbels, Goering, Himmler, Quisling, and Laval and demonstrates that they all had markedly maladjusted personalities. He diagnoses Hitler as a paranoid psychopath; Goebbels as a pathological liar; Goering as an aggressive neurotic character with addiction to drugs; Himmler as a pronounced sadist; Quisling as an abnormal Messiah; and Pierre Laval as an extreme egotist entirely devoid of ethical principles. It is remarkable how closely this author agrees with Lord Vansittart in his estimation of the German people and their responsibility for the two world wars. Lord Vansittart speaks as an experienced diplomatist, Abrahamsen as a psychiatrist specializing in criminal psychopathology. The former estimates the necessary period of close supervision of the Germans as 50 years, the latter as 75 years. Both agree on the supreme importance of re-education and both admit the extreme likelihood of failure.

In the reviewer's opinion, *Men, Mind and Power* is a very fine study of a psychopathological national reaction by a man who undoubtedly had great opportunities for observation during the invasion of Norway and who, by reason of his training in criminal psychology, was especially qualified to study the world's greatest criminals—as undoubtedly these men were.

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THE SELECTED WRITINGS OF BENJAMIN RUSH.  
 Edited by Dagobert D. Runes. (New York:  
 Philosophical Library, 1947.)

The publishers and the editor of the *Selected Writings of Benjamin Rush* should be congratulated on the compilation of this book.

Benjamin Rush was an active, rather restless soul, not profound but a lively and combative intellectual, a son of his age, yet in many respects above a number of his well-known contemporaries.

Alive to all and sundry problems of his day he was, like so many of the best of his generation in Europe or in this country, a man of encyclopedic trends. Thus he took an active interest in national politics, fighting against George Washington; he fought as violently (if not more so) with the Faculty and the Administration of the Medical College; he wrote on religious tolerance, on education, on internal medicine; he blazed the trail of American psychiatry; he condemned capital punishment and pondered on problems of psychotherapy.

One would wish that the editor had given us a more substantial essay on the life and work of Rush. His prefatory note to these "Selected Writings" appears a bit thin—more enthusiastic than detailed. Benjamin Rush was one of those rare personalities on this continent who presented a very original mixture of the restless nonconformism of the Renaissance with the moralistic pragmatism of the revolutionary thinker. In other words, his contribution is to be found not only in his writings and activities, but in his having been the person he was, the human being who *mutatis mutandis* may be compared with a Paracelsus, a Condorcet, a Benjamin Franklin, a Thomas Jefferson, or a Thomas Paine—whose good friend he was.

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THE PSYCHIATRIC STUDY OF JESUS. By Albert  
 Schweitzer, translated by Charles R. Joy, with  
 a foreword by Winfred Overholser. (Boston:  
 The Beacon Press, 1948.)

Much has been written recently about Albert Schweitzer. He has been variously presented as physician, theologian, missionary, organist, biographer, philosopher, and saint. He is one of this century's most gifted and versatile men and for the past 25 years has devoted himself almost entirely to the medical care of the natives in French Africa.

This slender volume, easily read in 30 minutes, contains Albert Schweitzer's doctoral thesis for his M.D. and first appeared in print in 1913. Prior to undertaking his medical studies, he had already distinguished himself in biblical scholarship and was prominent among those who attempted to found a concept of Jesus that would be historically valid. The quest for the historical Jesus seemed well completed by the first decade of the 20th century, when suddenly the questers, Schweitzer among them, found to their dismay that their formulation of Jesus had been awarded the diagnosis

of paranoia by certain disrespectful psychiatrists of the day. Paying for his medical examination with money gained from organ playing, Schweitzer thus ground three of his well-tempered axes by defending Jesus from the diagnosticians.

Early in his thesis Schweitzer gains easy victories over his psychiatric opponents. By relating the mind of Jesus to its cultural milieu, he shows that it was far from pathological to be thinking in terms of messianic missions, resurrection, the imminence of the Kingdom of God during the 1st century B. C., etc. He demonstrates that the term Son of God was purely idiomatic, and that to be a Son of God in ancient Jerusalem was, as far as concerns ego-aggrandizement, roughly equivalent to being a Son of Liberty in the Boston of 1775.

Schweitzer then encounters difficulties. Why should Jesus have such a high opinion of himself as to assign himself the leading rôle in contemporary theological cosmology? Schweitzer does not grapple with this problem directly, but excuses himself on the ground that the case history is short and incomplete. Later he seems to beg the question with a logic that would encourage anyone to call himself Napoleon, provided that he really were Napoleon.

Schweitzer inadequately defends Jesus from a charge of masochism, probably because he is so busy defending his subject from the diagnosis of paranoia or allied psychoses. Masochism, short of psychosis, may not be considered by Schweitzer to be a handicap, especially when ego-syntonic and in the guise of altruistic self-sacrifice. In his noted two-volume work on Johann Sebastian Bach he attributes to that musician a life-long and pervasive longing for death, and rather intends it as a compliment. It would seem that Bach and Schweitzer in their identification with Jesus have absorbed much of the latter's identification with the doomed sin-redeeming Servant of Isaiah. Needless to say, however, this *Komm Süßer Tod* attitude is far more mature and constructive than the *Götterdämmerung* attitude of some of Schweitzer's contemporaries.

Why is this book a disappointment? Chiefly because it does not live up to its title and to its author. Instead of being a psychiatric study of Jesus, it is essentially a refutation of other psychiatric studies of Jesus. Dr. Schweitzer would probably have done better to use his great knowledge in constructing his own version of Jesus' psychodynamics, rather than in orienting his entire work toward his opponents' theses. As it is, this volume will probably remain among the least of Dr. Schweitzer's works, and is to be recommended only to those who wish complete knowledge of his writings. For a clear and concise statement of the relation of modern psychiatry to Jesus, the foreword of Dr. Overholser is recommended. It is best summed up in Dr. Overholser's own words: "The perils of diagnosis at a distance are great!"

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